

The Psychiatric Quarterly

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DEPARTMENT OF MENTAL HYGIENE

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PSEUDOLOGIA FANTASTICA*

A Consideration of "The Lie" and a Case Presentation

BY THOMAS V. HOYER, M.D.

Pseudologia fantastica is a psychiatric term which rolls trippingly off the tongue, a term not frequently seen in the literature and about which not much is written. Yet it involves a phenomenon known to us all—lying, but more specifically, pathological lying. The pathological liar is variously understood by the layman and even by the medical and psychiatric profession. He is usually pictured as a criminal or a psychopathic character type, or, if we are more generous, we merely call him "an inveterate liar." Yet descriptively and genetically, it will be seen that there is a great deal more involved, with but little clear understanding. The literature is scant and sparse, with much overlapping of concepts. While not intended as a review of the literature, this paper will attempt to consolidate and clarify some of the bibliographical references with the help of a case presentation.

Pseudologia fantastica, mythomania, mendacity, and pathological lying—frequently synonymous in use—are all involved with the concept of a lie. The term "lie," seemingly simple in scope, will be seen to be highly complex in today's socio-psychological world. As usually understood, a lie is an untruth or falsehood, consciously uttered (or acted) to deceive. Two primary criteria would seem to be necessary: One, the person lying must know the untruth of his utterance; and, second, there must be a goal involved, either to gain an advantage or to avoid some unpleasantness.¹

Karpman² views lying in its many manifestations as a memory disturbance of a neurotic nature and also outlines other memory disturbances as distinguished from lying. He gives nine major classifications of lying, paraphrased here:

1. Benign or salutary lies—those not hurting others, or even lies preventing others from being hurt. Included in this group would be the lies of persons with a love of lying, such as are found in organizations like the Liar's Club.

2. Hysterical lies—those told to attract attention or to gain pity.

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3. Defensive lies—lies to extricate one's self from an unpleasant situation.

4. Compensatory lies—lies to impress others and to cover up inferiority, a mild form of which is the "keeping up with Joneses" motif.

5. Malicious lies—those done for profit, as lies by confidence men and the classical villains in literature—Iago in *Othello* and Edmund in *King Lear*.

6. Gossip lying—lying designed to hurt a specific person or to gain a personal satisfaction.

7. Implied lying—for example, cases of maintaining silence or refraining from telling the truth.

8. Love-intoxication lies—lies that are the overestimation and idealistic exaggeration of the love object.

9. Pathological lying—lying that may fall in one or more of the foregoing categories but is habitual in nature.

Karpman further outlines the way in which lying is, indeed, an integral part of our daily lives. Modern culture stresses good versus evil, rather than knowledge versus ignorance, or beauty versus the ugly; and most religions are oriented in the one direction—goodness. While honesty, goodness and virtue are represented as the "highest human good," lying, in its many varieties and types, is felt to be most reprehensible and the core of all human vices. To be able and willing to believe others, appears fundamental to the complete organization of interpersonal relationships.

"Lies are antisocial, regardless of their value to the individual."³ But, on the other hand, our very mode of living allows for—even creates—situations which make lying necessary. Indeed, our primitive urges, our loves and hostilities, if uncontrolled, if not socially conditioned, would prevent our social order from being self-sustaining. It becomes culturally imperative to repress and suppress the basically true and to express the socially desirable, even if untrue. Thus, as a matter of self-protection, any person in a meaningful conversation makes mental reservations regarding the truth of statements or opinions he hears. The possibility of intercepting lies makes us appear to be prepared in advance to sift out untruths we may hear.⁴ Examples in our everyday life are legion, many of which are probably seen in their true light by the sensitive, perceptive child. The growing child may be exposed to affectation, mental reservations, white lies, hypocrisy, concealing, distortion and exaggeration in his own home and thus be con-

ditioned to an anticipatory and even imitative attitude. Further representations in the outside world are ever in evidence with such examples as political graft, international diplomacy, and even much of our advertising, which utilizes deceptions and misrepresentations commercially.

To return to the subject, however, one must now consider the material which the pseudolog* represents to be true, but, which it turns out, is untrue. Is his story a falsehood which he recognizes as such and which is designed to produce a certain result? This, it will be seen, is incorrect or at best an oversimplification. The literature on the characterological neuroses is replete with stories of criminals and confidence men who are clever, adept liars in the usual sense of the word. Cleckley's *Mask of Sanity*,⁵ a study of the psychopath, shows this aspect well:

He is typically at ease and unpretentious in making a serious promise or in falsely exculpating himself from accusations, whether grave or trivial. His simple statement in such matters carries special powers of conviction. Overemphasis, obvious glibness and other traditional signs of the . . . liar do not show in words or manner. Whether there is a reasonable chance for him to get away with his fraud or whether certain and easily foreseen detection is at hand, he is apparently unperturbed and does the same impressive job. Candor and trustworthiness seem implicit in him at such times.

In what respect then does the pseudolog differ from this more common type of liar? First and foremost would be the fact that, by the definition and criteria for a lie, as given in the foregoing, the pseudolog is not a liar. Yes, he tells untruths or falsehoods, and a goal is certainly involved, but—the verbalizations are not consciously engendered, nor is the goal consciously recognized. Why then is this not considered a delusion? Because there is an aspect of consciousness present when the pseudolog fabricates his story. Is this, then, a contradiction of the previous statement? Not at all; for truly, the productions of pseudologia fantastica lie somewhere in the no-man's land between consciousness and unconsciousness. They are analogous to the fantasies and daydreams which we all have experienced, but from which we may snap back to reality at will. One investigator⁶ feels that the degree of belief (consciousness) involved in pseudologia fantastica lies in the half-way stage between such ordinary daydreaming and the full and absolute belief found in delusions. It is felt to be closely similar to the pseudolying observed in children.

*Kraepelin's term for the pathological liar or teller of pseudologia fantastica.

It is seen, then, that the pseudolog is not in actuality a liar. Karpman² lists *pseudologia fantastica* as a memory disturbance other than lying, and differentiates it from confabulations, retrospective falsifications, amnesia and hypermnnesia. Confabulations are the compensatory filling in of memory gaps found in organic and toxic psychoses and are indulged in by persons whose egos are unable to face the inferiority presented by memory loss. These productions are complete fantasy, fleeting and unstable, and will change from hour to hour or even minute to minute—not necessarily to be repeated again, but to be replaced by new ones. The form and direction of a confabulation may be influenced by the questions asked. In the pseudolog, basic memory is structurally intact, but memories are freely invented to satisfy the pressing and specific psychological need. Retrospective falsification is the inclusion of false beliefs in a system, and the subsequent projection of these false beliefs back to early childhood. Amnesia, hysterical in nature, is well understood and not to be confused with pseudologia. Hypermnnesia is seen in dreams, hypnosis, and delirious states and is the abnormal or extreme retentiveness of memory. *Pseudologia fantastica*, the subject of this paper, is variously described in the literature, often because the term is misused or misidentified with other types of lying or memory disturbances.

Healy⁷ describes pathological lying as follows, and gives as synonyms, *pseudologia fantastica* and *mythomania*:

It is falsification entirely disproportionate to any discernible end in view, engaged in by a person who, at the time of observation, cannot definitely be declared insane, feeble-minded or epileptic. Such lying rarely, if ever, centers about a single event; it manifests itself more frequently over a considerable period of years—or even a lifetime. Extensive, very complicated fabrication may be evolved.

Pseudologia fantastica is described by Hart⁸ as the relating of fictitious reminiscences with an air of truth—the giving of a detailed story of past life and experiences which is wholly imaginary. The fictitious past may be presented in such a manner that the person is seen as distinguished, influential and exceptionally interesting. The elaborate fantasies created are often ascribed to a personality with grandiose complexes. On that basis alone, may be seen the similarity between *pseudologia fantastica* and ordinary adolescent daydreaming.

The relating of stories is seen to be compulsive in character, probably accompanied by a pleasant feeling-tone, and is kept well

within the limits of possibility, only the total story bearing the mark of fabrication. The pseudolog, when confronted by exposure, will occasionally admit the true situation readily, but more often is untroubled and is only stimulated to further fabrication or inadequate evasions. It has been found impossible to make a reliable detection test in these cases by use of the lie detector.⁸ The pseudolog reaches a stage where he is no longer certain of what is true and what is not. His deception is undetectable by any method short of actual possession or discovery of the facts involved. It is generally agreed that he is not entirely unaware of the fact that his whole story is fabrication; but he, nonetheless, seems to continue to live in this dream world of his own—this half-way stage between daydreaming and delusion. This is a process of castle-building in an extremely egocentric individual, so much so that the person is always the hero of his fantasy or the recipient of much-deserved pity. Risch⁹ noted that his pseudologs would only fabricate when assured of the hearer's interest. In other words, the egocentric self-assertive drive was in need of a receptor in order to satisfy the psychic need of the pseudolog. Like the more common, clever liar, he is in action a glib talker, a veritable artist at his trade; he shows an aptitude for language and generally is a good conversationalist. He is disarming, not only to those unfamiliar with persons of his type, but often to people who, from experience or training, are supposedly on guard against his deceptions.

After this superficial look at what is produced or fabricated by the pseudolog, and after having described the pseudolog himself, a deeper investigation of the dynamics involved is in order. Both Karpman² and Fenichel¹⁰ tend to classify him as a hysteric or at least as a subtype of the hysteric. Fenichel states:

Considering the mechanisms of hysteria, it is to be expected that traits are manifested that correspond to the conflicts between intense fear of sexuality and intense but repressed sexual strivings. . . . Hysterical characters have been described as persons who are inclined to sexualize all nonsexual relations, who are inclined toward suggestibility, irrational emotional outbreaks, chaotic behavior, dramatization and histrionic behavior, even toward mendacity and its extreme form, pseudologia fantastica.

Mendacity may be thought of as an effect of the increase in fantasy. The castration complex, which injures the child nar-

cissistically, is an anxiety source which initiates infantile denial mechanisms.¹¹ The use of the infantile defense mechanism of denial constitutes *the first lie*. This objective denial is soon replaced by denial in fantasy. Through fantasy, reality is denied; it is transformed to suit one's own purposes and to fulfill one's own wishes. Anna Freud¹² points out that children's animal fantasies relieve them of objective pain and anxiety:

The child's ego refuses to become aware of some disagreeable reality. First of all, it turns its back on it, denies it, and in imagination reverses the unwelcome facts. Thus the "evil" father becomes in fantasy the protective animal, while the helpless child becomes the master of powerful father substitutes.

If the transformation is successful and the fantasy enables the child to become insensible to the reality in question, the ego no longer has anxiety and has no need to resort to further defensive measures or neuroses.

That this mechanism belongs to a normal phase in the development of the infantile ego, is easily appreciated. Later, however, the ego's capacity of denying reality is inconsistent with another prized function—the capacity to recognize and critically test the reality of situations.^{12, 13} In early childhood, this inconsistency has no disturbing effect, perhaps because the attachment of the infantile ego to reality is not firmly cemented. There is, in the earlier years, insufficient discrimination between reality and fancy (or make-believe). Young children are given to vivid fantasy, because their perceptions are limited and their concepts still generalized. A child's kindergarten drawing, often untrue with respect to reality, illustrates this. The mature ego with well-developed faculties of reality testing loses the power of using fantasy to surmount quantities of objective pain. The counterpart of this faculty in adult life is the daydream, which, at best, serves only to master trifling amounts of anxiety or to give the subject an illusory relief of a minor discomfort. The pseudolog then might be considered as having an ego fixated at this early level, an ego which continues to relieve anxiety, renounce instinct, and avoid neurosis by denying reality.

But fantasy alone is not the mark of a pseudolog: He attempts to engage others in his fantasies. The child is supreme in his fantasies; no one interferes if he keeps them to himself. In the pseudolog, however, the function of reality testing may be just

strong enough to cause him to seek buttressing of his defense. The dramatization of fantasies in word and act requires the world to be a stage. The value of the lie is in its nondiscovery.³ The denying effect is intensified, the defense is strengthened, if other persons (as witnesses) can be made to believe in the truth of the denying fantasy. In this way, the lie serves the purpose of the denial. The formula might be: "If it is possible to make people believe that unreal things are real, it is also possible that real things, the very memory of which is menacing, are unreal."⁴

Traumatic memories in childhood, anxiety-producing instincts and wishes may also be handled by repression. The facilitation of repression in children comes through the gathering of associatively connected screen experiences. Freud^{14, 15} has shown that the earliest recollections of a person often seem to be concerned with the unimportant and incidental, while frequently the adult memory shows no traces of the weighty and affective impressions of childhood. However, these seemingly indifferent memories owe their existence to the displacement or substitution of other really significant impressions. The associative relation of the indifferent memory to the repressed thought leads to the designation of "concealing memory" or screen experience. Screen experiences can also become part of memory through the construction of fantasies and games. Helene Deutsch¹⁶ indicates that the content of pseudologias consists of screen stories of actual occurrences. Pseudologia then can be thought of as an intermediate stage between the screen memory, the reality of which is believed in by the subject, and the usual fantasy, which is strictly distinguished from reality. However, it is stressed that the pseudologic production is not solely a breaking through of repressed memories. In fact, the specific form of breakthrough, that is, fantasy presented as reality, serves economically to entrench the repression further.¹⁰ Repression is thus facilitated by the formula, "Just as this is only fantasy, that [occurrence] was not true."

A second stimulus to pseudologias was indicated by Freud.¹⁷ He showed how absurd dreams, games and fantasies in childhood often are aimed at ridiculing adults. Another investigator postulates that pseudologic behavior may very well be revenge for having been deceived about sexual matters:¹⁸ "Since you lie to me in your way, I shall lie to you in mine." However, these efforts are directed at the external world and would seem to be

lacking in sufficient emotional stimulus to engender a repetitive complex psychological maneuver, such as is found in pseudologia fantastica.

Again, but less specifically, pseudologias may express the effort to maintain or increase self-esteem. Kanner¹ states that simple lying in a child may be only attention-getting. The need to be the hero of the day by entertaining playmates with exaggerated tales of exploits may be the child's way of escaping from a drab, monotonous life. This is aptly illustrated in a story by Cleckley.² It is the description of a personal friend who, he assures the reader, is not to be considered a psychopath. He cites it as an example of stories which are "...not delusion but the exaggeration and falsifying, sometimes conscious or half conscious, that are often seen in sane people and not infrequently in those who are able, intelligent and highly successful." It involves a Ph.D. in physics at a small but famous college, a man who is also the author of several useful and accurate contributions to the scientific literature. He often regaled groups of friends with accounts of working his way through the university by playing professional ice hockey at night, later setting type on a small newspaper for several hours, rising before daylight to stoke tugboats on the waterfront, traveling 34 miles to a high school to teach one subject and then 34 miles back, as well as keeping house in a three-room apartment which he shared with six aviators, and relieving the janitor of the building one hour of each 24. This would all be spoken of as being carried out simultaneously with full-time work at the university. He would describe in great detail and with apparent familiarity, the duties of these positions. Apparently he studied on the subway en route to these various duties. He was respected and well-liked by his students. It was the custom of each class to tabulate his age by the adventures and their duration when he would pseudoreminisce throughout the school year. His top age thus obtained was 169 years, and several classes bettered 150. One might conjecture whether such a person, successful and respected, could be classified as a pseudolog. It would seem that it might be possible: To say the least, the man well illustrates, both in manner and content, many of the attributes of this condition.

To return to the concept of lying and pseudologia as a type of memory disturbance, it might be of value to consider some additional findings. From a legal standpoint, it has long been recog-

nized that the value of evidence, as given on the witness stand is affected by many variables. As early as 1900, Binet¹⁹ called attention to "the advantage that would accrue from the creation of a practical science of testimony." In the years immediately following, this suggestion was taken up by Stern, of Breslau,²⁰ with the following results: A predetermined experience was submitted to a number of subjects who were subsequently interrogated to obtain an account of what they observed. The results are well known, to the extent that a popular parlor game developed. One variation of the game, called *Rumor*, consists of a single sentence being secretly whispered to each member of a group. This is done in a chain reaction pattern, so that each person receives the information and passes it along to the next. Another variation consists in passing a picture (showing some activity, human or otherwise) to each member of the group. After all have looked as long as they like, they are asked to relate, write down, or answer questions regarding, what they have seen. The results of these parlor games follow precisely the results obtained by Stern: The witness's report of his experience, even when given with the utmost honesty and conscientiousness, is rarely completely correct, and a proportion of the details, even those of whose truth the witnesses were certain, was erroneous. The usual maximum of accuracy was 75 per cent. When witnesses are interrogated with regard to details, instead of being asked to relate or narrate their story, the accuracy is greatly diminished, though the range of facts apparently remembered is increased.²¹

In this connection, then, one may correlate the perversion of memory or evidence with the phenomenon of screen experiences. Hart⁸ gives three stages of mental processes that are involved in the giving of testimony and the perversion of evidence or memory. They are perception, conservation and reproduction.

1. *Perception*—Through our individual interests, endogenous factors influence what we see. This process is accomplished through automatic selection and exclusion of visual stimuli. In addition, there is a perversive element, in that we often perceive what we expect to perceive rather than what has really happened.

2. *Conservation*—Having perceived or experienced, we now have to conserve the mental images. This is influenced, and often perverted, by simple forgetting and by active forgetting or repression.

3. *Reproduction*—The reproduction of what we have experienced or

perceived and then conserved is now influenced by factors of suggestion when questions are asked, and by the grandiose or self-assertion complex. This latter is seen on the witness stand and in the doctor's office. It can be attributed to a "center of the stage feeling"—an impulse to say something effective, to round out the story and fill in the gaps—in effect, to stage your evidence or memory so as to satisfy the canons of dramatic art.

Thus it is seen amply well that memory is an instrument whose reliability can be and often is disturbed by a multitude of factors—that, except by some measure of objective verification, no certain line can be drawn between actual reminiscence and fantasy. Lacking that objective verification, as is so often the case, it behooves the physician to remember that a patient's statements concerning events of his past can only be accepted with reserve. The factors producing these pathological effects, acting to varying degrees within the limits of normal, show the close correlation between reminiscence, daydreams, fantasy, and pseudologia fantastica.

A case history will illustrate descriptive, genetic and dynamic aspects of the pseudolog:

Case History

D. B., 36, is a white, divorced man, a veteran of four-and-one-half years of peace time and World War II state-side army duty. He was discharged in 1943 with a diagnosis of psychosis, unclassified. For four years, he made a marginal social and economic adjustment characterized by numerous jobs, alcoholism, and nomadism. Between 1947 and 1950, he was admitted a total of 19 times to three Veterans Administration general or psychiatric hospitals in the same metropolitan area.

These voluntary admissions were for various complaints including "hematemesis" (ingested red hair tonic), peptic ulcer (never demonstrated by x-ray), pain and swelling in his wrist (self-induced on a previous injury), nervousness, and alcoholism. In 1950, he was finally committed because of his numerous elopements and discharges against medical advice. He has had the following *psychiatric* diagnoses, the last of which was made at the time of his commitment:

- | | |
|--|------|
| 1. Psychosis, unclassified—CDD Army discharge. | 1943 |
| 2. No psychosis found—first Veterans Administration examination. | 1944 |
| 3. Immature reaction, emotional instability type, with pseudologia fantastica. | 1948 |
| 4. Paranoid personality, manifested by emotional instability and pseudologia fantastica, ideas of persecution. | 1948 |
| 5. Psychosis with constitutional psychopathic state. | 1948 |

- | | |
|--|------|
| 6. Personality defect, unclassified. | 1949 |
| 7. Neuropsychiatric diagnosis undetermined—after 44 days of hospitalization. | 1949 |
| 8. Psychopathic personality, pathological liar. | 1950 |
| 9. Schizophrenic reaction, paranoid type. | 1950 |

D. B. was born in 1920 in Texas. The birth was without complications, and he was breast-fed on demand until he was two years old. He was described as a fragile, sickly, high-strung, yet "cuddly" and affectionate child who did not cry much and posed no eating problems. He was slow in learning to talk and did not walk until almost two. Until he was four or five, he slept in the same bed with his parents and, for two years afterward, slept in the same room. He had enuresis until he was five or six; but despite these sleeping arrangements, his mother denies making this an issue! He did not have many playmates in his first five or six years; he tended to play with dolls and with his half sister (four years older) most of the time; and he received a good bit of attention from the adult friends of his parents.

The father was a billposter and part-time stage hand who was described as somewhat unreliable in his financial and job situations, but as a kind, friendly, nonpunitive father. When D. B. was six, he witnessed his father's convulsive death. The father, it was learned subsequently, had central nervous system syphilis. The mother was never close to her own parents and was naïve and "uneducated regarding sex" before her first marriage. Her first husband had died of influenza. None of her pregnancies were planned.

Following his father's death, the family lived with the maternal grandparents, and D. B.'s mother went to work. During this period, the patient seemed very attached to his mother and appeared threatened by her leaving for work each day. It has since been noted that he cannot tolerate long separations from his mother, and proximity must be maintained. The first indication of his penchant for fantastic tales occurred sometime between his father's death, when D. B. was six, and his mother's subsequent remarriage, when he was eight. He was attending a Catholic school, because originally, he was too young to enter the public school with his older half-sister. He came home early one day, saying that a child at school had been bitten by a snake and had died, and that, therefore, there would be no more school that day and none the next. This was proved to be a complete fabrication.

When D. B. was eight, his mother married her present husband. D. B. was reportedly pleased at the prospect of getting a "father" and a "brother." In the beginning he got along well with his stepbrother, four years his junior, but jealous rivalry for the father's attentions led to strained relationships. All hospital reports and social service records in-

dicare that the patient has never gotten along with his stepfather, who is high-tempered, verbally abusive, and consistently unable to admit his own errors in judgment! Initially, also, the family financial status changed from penny-pinching to virtual luxury. Then it was back in a short time to depression, poverty, and charity-relief status. The two half-sisters born of this third marriage by the mother are 12 and 13 years younger than the patient.

When D. B. was between 10 and 18 years old, there was a series of moves back and forth between Michigan and Texas, with the patient occasionally living for short periods with relatives. With schooling frequently interrupted, he was behind for his age, and this was evidently traumatic socially. A school teacher was reported as observing that the other children tormented him, calling him an "idiot," and that he would neither fight nor play with them. At 15 or 16, he finally quit school in the seventh or eight grade and lived with an aunt and uncle on a dairy farm. He enlisted in the army at 18 at the same station where his own father had enlisted years before. The mother reports no sex education was ever given and denies knowledge of sex activities on the boy's part.

For a few years in the army, there was no evidence of maladjustment. Then, in 1941, D. B. met and became engaged to a 16-year-old girl, who, it was later inferred, was interested only in a possible allotment and his G. I. insurance. Despite formal educational deficits, the patient was then in officer candidate school and appeared slated for overseas duty. He was married in 1942, but the wife continued to live with her parents; and the patient reports that he had no sexual intercourse for the first three weeks, because of the interference of the girl's mother. The patient's own mother recalls that his behavior and attitude changed from the beginning of his association with this girl. He was afraid he would lose her, neglected army duties, began drinking, fabricated excuses for furloughs, and became generally unreliable. He was considered unfit for overseas duty, was dropped from officer candidate school, and was demoted to private. Trouble with his wife and in-laws continued, and finally divorce proceedings were started after nine months of "marriage." Six months later, he was hospitalized for "nervousness," following which he was discharged with the diagnosis of "psychosis, unclassified." The patient's assertions about this entire period include stories of an abortion done to his wife at her mother's instigation and reports of sexual relationships between his commanding officer and this mother-in-law.

When first home from service, D. B. was moody, emotionally unstable, drinking to excess and expressing many strange ideas about his army service and his ex-wife. When he began to work, his jobs were irregular, brief, and interspersed with alcoholism. He liked the excitement of being an ambulance attendant best. It was noticed that he began to have fre-

quent "accidents" on the job, with claims for compensation following. It might be inferred that, with the advent of his hospital contacts, he was exposed to the dependency-fostering, supportive nature of pensions, institutional awards, compensation, and even of hospitalization, per se. Also, he may have found more fertile ground for the implantation of his fantastic stories. (Concomitantly, his alcoholism has continued—low-grade but chronic—and barbiturate and chloral hydrate intoxications have been seen.) At any rate, in 1947, four years after his army discharge for "psychosis," the first of his many hospitalizations commenced.

The stories given in his psychiatric histories are, in every sense of the word, representative of the productions of *pseudologia fantastica*. To list them in detail, would be highly entertaining but beyond the scope of this paper. Essentially, he is either the hero of tremendous exploits or the unfortunate victim of life's trickery. The ease with which his ideations could be considered delusions can be seen by the following:

His wife was raped by his commanding officer, following which her health broke, and they were divorced.

He worked as a narcotics agent and was involved in a big investigation at Sawtelle Hospital. After testifying in Washington, D.C., on this case, he was shot at twice and is sure someone is out to get him.

His rich uncle died and left him the ownership of a famous expensive, local restaurant.

The degree to which his storytelling is capable of fooling others is well illustrated by the excerpts, quoted from a neuropsychiatric consultation early in his hospitalizations:

"There are no nurse's or doctor's notes indicating the ward behavior of this patient. This is disconcerting because of the previous diagnosis of Paranoid Personality. Paranoids are classically capable of presenting good fronts for brief periods of time, especially during examinations. The patient presents a very colorful history. It seems that practically everything has happened to this man in his twenty-eight years of life."

Then, after mentioning some extremely improbable events as related by the patient, this psychiatrist goes on to say:

"One can see no reason for the diagnosis of Paranoid Personality, that is, *providing the story is a true one. . . . It is all certainly possible*. He has no insight into any personal problems which might be upsetting him, and I was able to learn of none, *except for the reality situation which, I would think, would make anyone nervous*. The reality is that he has been shot at twice since his return from Washington, and he is sure someone is out to get him in regards to the Sawtelle

investigation. I believe he is much more shaken by this investigation and its possible consequences than he admits to himself."

That was in 1949. It may be added that as late as 1954, thoroughly trained and competent psychiatrists—perhaps misled by the final diagnosis of "schizophrenic reaction, paranoid type," found themselves believing some of this patient's rather fantastic assertions, which were not of a persecutory nature.

D. B. has thus shown himself to be a malingerer; he has constant somatic complaints; his oral needs are constantly demanding; he frequently exhibits hysterical qualities; he varies between grandiosity and piteousness in his stories; and the degree of functional and social impairment is probably of psychotic proportions. However, he is not delusional in the true sense of the word, and has admitted some of his fabrications to the writer. He has never been seen hallucinating, and all of his sedative and hydrotherapy prescriptions in the hospital have been on the basis of characterological acting-out.

In the years since he was diagnosed schizophrenic, he has had 47 insulin coma treatments, 15 electric shock treatments, and hypnotherapy, all of which left him looking clinically as he did years before. Psychological tests were given in 1950. They included: Wechsler-Bellevue, Thematic Apperception Test, Rorschach, Grayson Perceptualization, Bender-Gestalt, Sentence Completion and Draw a Person. In summary, they indicated that schizophrenia was ruled out, with the "delusions" more like pathological lies. The main focus was seen to be unresolved Oedipal attachment for his mother, with concomitant castration anxiety. Defensive efforts were seen as consuming much psychic energy, leaving little for personality growth.

A second battery of tests was given in early 1955, including the Maps, Rorschach, Wechsler, Sentence Completion, and MMPI. They indicated no important basic changes since the testing in 1950. D. B. is believed to be distorting his environment to suit his own needs, but the distortions are not similar to those of psychotic patients and do not succeed in reducing his anxiety, which further interferes with his already poor emotional integration and makes him incapable of using his good intellectual potential in thinking life's problems through. He was considered primarily a character disorder.

The writer's first contact with D.B. was as ward doctor in late 1954. Needless to say, the writer, too, was taken in by his pseudologic proclivity. As the patient was being prepared for a trial visit away from the hospital, (he had made many such in the past) he began to fabricate. It suddenly became almost painfully clear that he was not ready for release and that something had been

overlooked. A close review of his voluminous records indicated the true nature of his illness and led to the writing of this paper.

In early 1955, the writer attempted a new "approach" to this patient. This involved superficial explanation to him of the doctors' present understanding of his illness and conduct, and was followed by confrontation with his fabrications, when they were detected. Knowing that fabricating was not completely under his conscious control, the writer suggested that he would help the patient to be more aware of his "lying" whenever it became evident. The wisdom and rationale of this approach was, and is, open to question. In answer to D. B.'s statement that he lied to others because he had been lied to by the hospital and the doctors, the writer proposed a "cessation of hostilities" and a mutual condition of complete honesty between writer and patient. He initially showed improvement with this friendly supportive technique. He was given less opportunity and less need to fabricate—and less fabrication ensued. Oral needs and dependency continued however.

During the next year, the writer continued to see him for supportive psychotherapy, although he had a succession of three more ward physicians, and meetings were somewhat irregular. His pseudologia continued, and varied inversely with his demands for oral medication. Definitive plans were accomplished for his living at the "domiciliary,"* but the threat of increasing independence was again too great. Symptoms increased—fabrications, ward manipulation, acting-out, intoxication, and so on—and D. B. was finally restricted, with few or no privileges, for two months. Throughout this period, thorazine and serpasil were of no help.

In March, April, and May 1956, the writer saw the patient regularly once a week. His hospital adjustment was improving. At this time the writer elected to change his therapeutic approach. Rather than confrontation of the pseudologia, disinterest in it was affected, while, at the same time, a friendly, supportive, and accepting attitude was maintained toward D. B. as a person deserving of interest in his own right. From time to time the patient would pop up with a "test lie," which would be listened to without comment, or with a noncommittal comment, followed by continued discussion of the previous subject matter.

*A veterans home; not a hospital but a place of residence; a facility of the Veterans Administration and part of the VA Center, Los Angeles.

This resulted in two things: To the writer, as his therapist, he told fewer and fewer "lies." He became more friendly and seemed to appreciate the acceptance of him as he was, rather than as he would occasionally fabricate himself to be. When no comments were made, he dropped the subject involved in his pseudologia and made no further references to it. (The content of these fabrications centered about a theme recurrent since 1947, D.B.'s marriage to a student nurse. One story told of an FBI investigation at Brentwood Hospital involving D. B. himself, since he had been "making book" on the races for the doctors and staff.) The second result of the changed approach was that D. B. concomitantly became an increasing problem to his ward physician, who had to impose a more stringent reality on him than the writer did himself. Physical complaints, oral demands, and criticism of his treatment increased. As ward management problems increased, it was felt that the writer's approach was interpreted by the patient as approval of his demands and actions toward his ward doctor. Because of the anxiety aroused in this conflicting approach between therapist and ward doctor, the patient ran away while on weekend pass, and the next day was applying for admission at the Veterans Administration Hospital, Palo Alto, Calif.

Even before his records could be transferred, it was felt at Palo Alto that he presented a character disorder. No hallucinations or delusions were noted. He was co-operative and pleasant, and told a plausible and accepted story which was, however, pure fabrication. Dependency needs were recognized, but were not so evident as previously seen at Brentwood Veterans Administration Hospital.

Despite a less suspicious, more satisfying environment, D. B. was apparently unable to remain away from the near vicinity of his mother. While he was on leave to Los Angeles, he became intoxicated and was of necessity returned to Brentwood Veterans Administration Hospital. The psychological tests completed at Palo Alto revealed distortions suggestive of psychotic delusions, but no psychosis was found. The impression was of a character disorder in a paranoid personality. Miltown, thorazine, and reserpine had been found ineffectual.

Upon his re-admission to Brentwood, he was demanding, aggressive, and hostile; but he made an adequate adjustment to closed ward routine despite continued—but virtually unsatisfied—oral

demands. Beginning in January 1957, he has made an increasingly good response to a firm, authoritative open ward approach, with reserpine as his only oral medication. Manipulative attempts to receive other oral medication and physical attention were still made, but he went on full privileges and started working, part time, away from the hospital in March 1957. Although no essential change in character structure or in dynamic needs has occurred, the therapeutic approach has been built around a closer understanding of his pathology. His *pseudologia fantastica* is recognized as a manifestation approaching psychosis, yet lying within the structure and bounds of a character disorder. Prognosis, however, is generally recognized to be very limited.

This patient's life history, and psychologic and psychiatric examinations aptly illustrate the three major factors postulated earlier in this paper to be dynamically operative in the manifestation of *pseudologia fantastica*:

1. Unresolved Oedipal conflict, with severe castration anxiety.
2. The successful attempt to ridicule and get revenge on adults for earlier disappointments.
3. The need to increase and maintain one's self-esteem.

Fixation on, and/or regression to, the oral phase of psychosexual development is clearly evident, and the strengthening of the defense by engaging others in the fantasy has been recognized—if painfully.

SUMMARY

The literature on lying, psychopaths, and pathological lying is reviewed in part in an attempt to consolidate and clarify the concept of *pseudologia fantastica*. Classifications of lying and social reactions to lies are described. The lie, consciously recognized as a falsehood and designed to produce a certain result, is distinguished from the pseudologic production, whose falsity and goal fall some place between consciousness and unconsciousness. The differentiation from delusion and memory disturbance is described. The pseudolog's story is analogous to fantasies and daydreams, and his degree of belief may lie in the halfway stage between ordinary daydreaming and the full and absolute belief of a delusion. Basic memory is structurally intact, but memories are freely and almost unconsciously invented to satisfy pressing and specific psychological needs. The factors felt by various authors to be important in the dynamic understanding of *pseudologia* are

presented. A case presentation illustrates these factors which are seen to be (a) unresolved Oedipal conflict with severe castration anxiety, (b) successful ridicule and revenge on adults for earlier disappointments, and (c) the need to increase and maintain self-esteem.

Veterans Administration Hospital
Marion,
Indiana

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PSYCHIATRY IN GREAT BRITAIN TODAY. I*

BY CECIL BERESFORD, M.B., B.S., L.R.C.P., M.R.C.S., D.P.M.

NOTE: *A group of informative lectures (Parts I and II of this paper) was presented by Dr. Cecil Beresford, physician-superintendent of The Retreat in York, England, to the staff of the New York Hospital—Westchester Division in October 1958. There has been a close association between the English and New York hospitals since their earliest days. Thomas Eddy, who became a governor of the New York Hospital in 1793, took a great interest in the more enlightened and humane treatment of the mentally ill in England and France than prevailed in this country. He was particularly impressed by the good effects of the treatment procedures at The Retreat in York, founded by William Tuke and brought before the public through the writings of the founder's grandson, Samuel Tuke, particularly the Description of The Retreat, published in 1813, a work which had wide influence in the establishment of other institutions and in reforming psychiatric treatment policies.*

Thomas Eddy was immediately impressed and in 1815 advocated the founding of a psychiatric service where the newer forms of treatment, then known as moral management, could be instituted. By moral management was meant the humane, kindly treatment of the patient in as rational a manner as his state of mind would allow, the elimination of all force and restraint up to the point of safety, the use of physiotherapy, occupational therapy, diversion, recreation, regular religious services of all faiths, social events, dances, music and reading—the therapeutic measures spoken of today as program therapies.

The separate psychiatric service of the New York Hospital, established on the present site of Columbia University in New York City in 1821, was known as Bloomingdale Asylum. The name

*Part I of this paper includes Sections I and II (the first two of Dr. Beresford's four lectures at the New York Hospital—Westchester Division. The third and fourth lectures will appear as "Psychiatry in Great Britain Today. II," in the July 1959 issue of THE PSYCHIATRIC QUARTERLY.

was later changed to Bloomingdale Hospital which, in 1894, was moved to White Plains, N. Y. The name of the hospital was changed to the New York Hospital—Westchester Division in 1936 in order to convey a clearer understanding than had hitherto prevailed of the relation of the hospital in White Plains (in Westchester County) to the Society of the New York Hospital.

Through the years, the governors and physicians of the two institutions have corresponded and visited, with resulting mental stimulation. Recently both hospitals have become more fully involved with the mental health needs of their local communities in the operation of out-patient service and through programs of teaching and research.

JAMES H. WALL, M.D., *Medical Director*
New York Hospital—Westchester Division
White Plains, N. Y.

I. GENERAL SURVEY OF FIELD

This discussion will deal with the treatment of psychiatric illness as practised in Great Britain. First, the whole field will be surveyed in a general way to give the background of the specialty, or perhaps the word should be specialties, because psychiatry has already split up into a number of fairly distinct branches. To give a coherent picture is not easy, because, by its nature and evolution, the subject is diffuse. In psychological medicine, we all know, for example, that we are dealing with diseases, of which the classification is still based in the main on symptomatology, and not etiology. Again, the specialty has clearly developed along various channels, often quite unconnected with one another. This is often because of ignorance and prejudice on the part of the public, and even more so on the part of medical colleagues who are not of our speciality. This, the writer thinks, has produced much greater disunity than in other branches of medicine. Finally, during the last dozen years, the nationalization of medicine in the United Kingdom has affected all medical practice profoundly, and, in certain directions, psychiatry more than most. The subject, therefore, has to be described fairly carefully if muddle and confusion are to be averted.

If one looks back to the start of this century, he discovers that the whole matter was fairly simple. There were insane people; and doctors, usually referred to as alienists, looked after them in places known as lunatic asylums. Mental defectives were recognized as being different from the "insane," but were usually looked after in the same asylums. That is, a defective was sent to an asylum if he was too much of a nuisance to be allowed to roam at large about the country as "the village idiot," of which most places had at least one. The most astounding superstitions were current about these institutions, however, and most people seemed to believe, as the writer remembers believing himself before he studied medicine, that the lunatic was certified, locked up for life and, if he proved too troublesome inside, was quietly and painlessly "put to sleep." To be an asylum doctor, therefore, was not a particularly respectable thing; and, no doubt, the work often attracted a type of doctor and nurse, looking for a lazy, irresponsible, and even alcoholic, existence.

This tradition lasted in England till fairly recently in some parts of the country. When I told the dean of my medical school that I was taking up this work, he nearly got on his knees to dissuade me, not because I was particularly promising in his eyes, but because he believed it a fate too horrible to contemplate for any of his students.

Although Freud's teaching had emerged some years before on the Continent, it was slow to penetrate elsewhere. The neuroses had hardly been recognized as an entity before World War I. Hysteria was described, but hardly distinguished from malingering; and, even more, were the anxiety and obsessional states looked upon as moral flabbiness when not attributable to some physical cause or other. Even after World War I, during which a huge number of neurotic cases emerged from the long-continued battle-strain of trench warfare, and doctors had to learn to treat them, the speciality, if anything, became even less respectable. Freud's theories, which were, of course, brought into prominence by the wartime neuroses, were misunderstood and were still far in advance of public education. They were just looked upon as positively indecent, the prurient philosophizing of a sex-obsessed foreigner.

One would have thought that the two outcasts, the alienist and the psychotherapist, would have found companionship in their

misfortune. Not a bit of it! They became rivals at once, developed separately, and usually with little attempt to benefit by each other's discoveries. Even today, they debate when they meet, with far more heat than reason. For the most part, the alienist treated his patients in the hospital, any consultation outside would usually be merely with a view to deciding for or against admission to the hospital. The doctor treating the neuroses almost invariably treated patients away from institutions, and indeed was sometimes known to warn a patient who tired of treatment, that insanity, and so the mental hospital, would be the alternative, of perseverance and cure. To the alienist, the psychotherapist was a charlatan; to the psychotherapist, the alienist was a "dim-witted jailer." This state of affairs was particularly unfortunate, as the psychotherapist had little opportunity to learn the limitations of his therapy among severe psychotics, and the alienist little chance to see early or mild cases of psychoses or any of the psychoneuroses, and so learn the value and technique of psychological treatment.

Between the wars, a slow *rapprochement* began. The extremists in either camp could still mention the other only with contempt and hostility, but the majority got together and, largely under the auspices of the Royal Medico-Psychological Society of Great Britain, devised comprehensive schemes of training in psychiatry, with an examination and diploma in the specialty. Such training insisted on each psychiatrist doing a basic minimum in every field: that is, spending some time in a mental hospital dealing with the fully developed psychoses; a period attending the clinics which were gradually established in general hospitals and which dealt with out-patients suffering from neuroses and mild psychoses; a period attached to the neurologist of some general hospital; and a period of internship in a mental deficiency hospital. These last hospitals, at first very few throughout the country, had increased considerably, as nearly every county found its mental hospital, in which it had previously housed its defectives, so overcrowded that it had to build a mental deficiency hospital to free the mental hospital of the load of defectives it carried.

Just before World War II, the child guidance movement, begun in a small way several years earlier, gained momentum, and nearly every town acquired child guidance clinics, under the control and direction of the education authorities but with a psychiatrist always as one of the team. About the same time, the scientific

study of delinquency became established with a few psychiatrists employed solely on this work, some by private philanthropic associations, others by the state in His Majesty's prisons.

In these five subspecialties, there were some psychiatrists working privately and others employed on salary by public bodies, mainly county councils. In all psychiatry, however, there had always been a much smaller proportion of private specialists than in most other branches of medicine, but the proportion was smallest of all in mental hospital practice. Even so, the field would appear fairly clear-cut in theory, as to curriculum, career and ultimate status. A doctor trained as a psychiatrist, getting experience in all branches, and then entered the subspecialty of his choice. Unfortunately, this did not turn out so in practice. Almost every university began to run a course for its own diploma in psychological medicine, and it depended very much on the professor as to what form the course took. Professor Brown of Oxcastle might be "physio-genic" in the extreme and turn out psychiatrists who detested the name, psychoanalysis. Professor Grey of Camchester might be a psychoanalyst and put the strongest pressure on his pupils to undergo training analysis, while Professor White of Brisford might be a "bandwagon" merchant, pride himself on keeping his balance in the middle of the road, but be accused by both other professors of merely sitting on the fence. One university appointed a professor whose only interest was child guidance, and his finished pupils were often only fit to do that work.

On top of this rather muddled state of things, came the advent of state medicine at the end of a long war which had impoverished the country very considerably; and, contrary to many expectations, far fewer people could afford private treatment than was thought likely at one time. There is, therefore, a situation where not only are opinions on causation, outlook and treatment, as from doctor to doctor, more completely varied than in any other specialty, but where economic factors influence the treatment of choice far more than in any other branch of medicine. For example, if you had a serious but fairly common surgical condition, the decision when to operate would nearly always be agreed upon by most surgeons, and your finances would only settle whether the operation were done privately or in a state hospital. If you had a severe psychoneurosis, even if your psychiatrist decided deep psychoanalysis was the treatment of choice, you would have to try

something else if you hadn't money to pay for it privately; and it is a very, very small proportion of the public who can pay for deep analysis nowadays in the United Kingdom.

This last point is made to correct the impression that may have been given by the way in which the progress of psychiatry has been traced: namely that all the opinions of psychiatrists on these matters are reasoned and clear-cut. Obviously economic factors operate in the mind, subconsciously as well as consciously, and help to mold the theories of the various schools of thought. That the state service, after only 10 years, cannot hope to have stabilized itself, will explain why the position is still very fluid, to use a favorite war-time phrase.

And now to try to classify some of the main schools of thought. First, the psychoanalytical school can be mentioned as the one that can probably be disposed of most easily, in this general survey at least. It has lost a good deal of ground in the last 20 years, and the writer knows few, if any, psychiatrists who are now thorough-going Freudians in the sense of following Freud's theories and technique with only minor modification. The Institute of Psycho-Analysis continues, of course, and the Tavistock Clinic in London still insists in the main on any new member taken on the staff having had an orthodox training analysis. The Portman Clinic, too, where delinquents are studied, is also completely Freudian in orientation. To the writer, it appears, however, that many individual psychiatrists associated with these two clinics pay a good deal of lip service to the master, and in practice diverge pretty widely from his teaching. In state medicine, there is hardly any room for the technique. It would be ruinously expensive in doctor-time and is just impractical. Certain hospitals and out-patient clinics maintain a trained psychoanalyst, but the work that goes on is really to be regarded as experimental, that is, the attempt to discover a shorter technique, rather than any solution of the problem of treating the large number of psychoneurotics with the present technique. In private practice too, the school is losing ground, if only because of the rapid diminution in the number of people able to afford treatment and who are still at an age to make it even a reasonable proposition.

Only in child guidance, has psychoanalysis maintained its position rather better. The leading psychiatrists in this field stress the importance of a training analysis, and, with the increase in

the number of child guidance clinics throughout the country, psychoanalytic influence in this field has, therefore, remained fairly strong. This matter will be dealt with more fully later, so there will be no deviation at this stage to mention the emergence of some recent opposition. In mental hospital practice, the psychoanalytic school of thought was never more than fragmentary, and the writer knows of no one who attempts the use of deep psychoanalysis as a routine form of treatment for in-patients or out-patients of a psychiatric hospital. On the other hand, the number of fanatical opponents has lessened considerably, and it would probably be fair to say that most psychiatrists in this sphere of the specialty look upon Freud as the pioneer, a great man who introduced entirely new concepts and theories, many of which help to understand patients so much better; but these same psychiatrists would accept his teaching in toto and the technique he evolved unmodified as a modern practical therapy, just as soon as they would try to base a system of modern general medicine on Aristotle.

The Jungian school can be dealt with even more briefly, having undergone an even greater eclipse. There are still one or two Jungian analysts in practice, but they talk to and of one another rather as do the last survivors of some distant historic event—as the last veterans of the American Civil War did—and their influence would appear negligible. There is still a good deal of interest in Jung manifest in books written by what one might call amateurs or “dabblers” in psychology, but consideration of this is outside the scope of the present discussion.

The greatest cleavage in thought—particularly, but not exclusively, in mental hospital work—comes, of course, in the divergence between believers in the physiogenic and believers in the psychogenic causation of psychiatric illness. The writer would say that at the moment the balance is about even, in that the professors in psychiatry of the various universities are equally divided. Each regional hospital board has usually one university within its regional area, the professor of which tends to set the tone for that region. The whole country is split up into a dozen or so such regions. There are a number who look upon all mental and nervous illness as produced initially by inborn constitutional causes. They think that these determine willy-nilly the development, sooner or later, of physical or metabolic changes that give rise to the symp-

toms of nervous or mental disease. They incline to give environmental factors the very smallest importance. They recognize really severe and long mental strain as a possible precipitant, and of course advocate its removal wherever possible, but they see no point in discussing such a factor at length, believing it cannot be of much moment if it is not big enough to be obvious. Still less do they consider the painstaking investigation of past stresses in childhood or earlier life to have any curative value. Probably about an equal but still limited number take the opposite viewpoint, that is that psychological factors are paramount, that they are adverse influences either in the present environment or in the patient's past. Physical conditions such as cerebral arteriosclerosis are looked upon as contributory, but not in themselves decisive, in the causation of psychiatric illness.

The main body of opinion would appear to be in between these two extremes but in recent years seems to be tending very definitely, if still only slightly, toward the former viewpoint. There is inclination to believe that nearly all the psychoses have a physical basis, in structural or metabolic deviation from the normal, and that there is only variation in the degree to which individual psychiatrists believe mental disorder can be produced by a psychological cause. As has been implied, there has recently been noted a tendency for more psychiatrists to belittle the importance of psychogenic factors.

Similarly in the neuroses, the majority would again stress the importance of the patient's constitutional nervous makeup; and though more frequently accepting environmental stress as a precipitant, the psychiatrists who take a very modest view of what psychological treatment can produce in the way of complete cure of a well-established neurosis, are certainly in the majority. It is not surprising, therefore, to find that physical methods of treatment—and drugs are included under this heading—predominate in mental hospital practice. Here, again, economic pressure—too few doctors for too many patients—plays a large part, of course, in deciding this line of action.

Rather paradoxically, another large and influential body of opinion inclines very much in the opposite direction; and it is in what is, and what should be, the most important aspect of psychiatric work; preventive psychiatry. Only rather lately has there grown any clear-cut organization to deal with the prevention of mental

illness. Before the calamity of mental illness had occurred, the psychiatrist was not called in. Now all local authorities have their mental welfare departments, but most of them still concern themselves primarily in seeing that Mr. X is duly sent to a psychiatric hospital if he needs to be. There are many mental welfare departments that do praiseworthy work in following up discharged cases to see if recurrence can be prevented. A small but growing number have developed mental hygiene machinery with, in one or two instances, a medical officer of mental health. The latter, however, is often almost totally immersed in administrative detail, and nearly all the work is done by psychiatric social workers, some "duly authorized officers" and some voluntary social workers. These persons are not usually hospital-trained, let alone medically qualified, but they have had thorough groundings in psychology while taking degrees or diplomas at a university. This training is weak in that it tends to be theoretical rather than practical in many instances. For example, one such worker recently came to the writer as a patient. She had had three years in the university and only four and a half months of practical work. There is little doubt, therefore, that the emphasis is placed more on the psychological than on the physical aspect of psychiatric illness in this important and growing body of workers in the specialty. Perhaps it is healthy that one side tends to balance the other, but the crying need is for research and assessment, for which as yet there has apparently neither been the time nor the money to spare. The need for more research (for example, in doing case histories among controls as well as patients, and comparing the results of treated and untreated neurotics) is being voiced more frequently, and one hopes such a project will soon materialize, but with so much work and so few workers, there has been little important research done in this field as yet.

As far as the subspecialty of mental deficiency is concerned, there has been a considerable amount of research activity. After a long, rather sterile gap, when the morbid anatomy of the central nervous system had been examined and classified to bring about apparent finality, further research has proved fruitful along the lines of inquiry into such matters as infectious diseases of the pregnant woman, the relationship of different blood groups in the parents, genetic influences, and so on. From the management point of view, the great scarcity of beds in the mental deficiency hospi-

tals—which occurred almost as soon as they were built—produced a state of affairs that made it inevitable to provide care outside institutions, for a time at any rate. It was found that, with suitable schools for the younger and with appropriate supervision for the older, to prevent the defectives' exploitation on the one hand, or their proving a nuisance to the public on the other, a very big percentage were better and more economically looked after outside a hospital. This has given rise to a strong move to release from certificated detention as many defectives as possible, in anticipation of the new Mental Treatment Act expected in 1959. It has been found possible to discharge from certificates nearly 90 per cent of the defectives in hospitals, and though most are retained there as "informal patients," a sizable number have shown themselves capable of living useful and happy lives in their own homes with some supervision from the mental welfare departments of their home towns. It has been made very clear indeed that, apart from the low-grade ament who obviously needs hospital care, the deciding factor in most cases is not the patient's dullness but his emotional stability. In other words: How psychopathic is he, not how defective?

And that appropriately enough brings up the problem, which, the writer supposes, is as vexed a question in the United States as in Great Britain, that of the psychopath and what's to be done for him. Again it is clear that in Britain the preponderance of psychiatric opinion looks upon the condition as constitutional. The school of John Bowlby—with its emphasis on the deprivation of mother love—and somewhat similar theories of psychogenic causation, have lost much ground following the expounders' inability to produce any curative results by treatment based on their theories. This is hardly fair, when no treatment based on any other theory is noticeably any more effective, yet the fact remains that most psychiatrists in the United Kingdom believe that the various childhood stresses that have been held responsible for psychopathy have only accentuated a tendency already inborn, if indeed they have done as much as this. Many would say that the signs of anxiety, fear and the like that can be shown to have occurred in certain cases, when as children they lost their mothers temporarily or permanently, were just the first manifestation of this inborn instability. In only one hospital, Belmont, does the writer know at present of a really constructive effort to investigate and deal

with this problem of the psychopath along lines that may have practical application. The Belmont program is based on a general assumption that the trouble is due to a kind of deficiency in social instinct. The patients are being treated along group therapy lines with numerous variations, and the routine is producing very interesting and valuable information, as well as an occasional good result. Naturally, too, there are occasional disasters, as when part of the place was burned down some time ago. A northern school holds psychopathy to be a metabolic aberration to endocrine dysfunction, but biochemical research along these lines has hitherto produced no results that have had any practical application. The same can also be said of the school which believes it due to abnormality in the microscopic structure or functioning of the central nervous system. Research goes on, and though abnormalities can often be shown in the EEG (and of course they are often not shown) in the worst cases, no worthwhile line of treatment has emerged.

The expected new act envisages provision for the delinquent psychopath who is in need of custodial care for the welfare of the community. Some psychiatrists feel it right to accept such persons in a mental hospital, apparently on the grounds that they are really sick people, and should not, therefore, go to prison, and yet that there is nowhere else for them to go. An equally strong body of opinion would refuse to admit these people—and the medical superintendents of state psychiatric hospitals are to have this right of refusal under the new act—on the grounds that psychopaths unsettle the other patients and prejudice their chances of recovery. Other doctors would refuse admission to psychopaths on the grounds that if such patients are admitted, this procedure will deal with the situation badly, whereas refusal would force the government to build suitable and separate hospitals for the psychopaths. The unstable dullard is provided for, but the psychopath of average or high intelligence is still a very big problem, of management as well as of treatment.

Finally, let us turn for a short glance at the subspecialty of delinquency. There are some, and still quite a sizable minority, who would consider every habitual criminal a psychopath in need of treatment rather than a person in need of corrective punishment. The distinction is, however, still generally made between the psychopathic delinquent who is said to show delinquency or anti-

social aggression as merely one symptom among many others showing psychopathy, whereas the criminal appears intelligent and stable in every respect other than his proclivity to crime. The psychiatrist's first entry into this field was not too happy. Some years ago, there were claims that the psychiatrist was the chief authority on the cause of crime and the best way of dealing with it. Unfortunately, he did not produce the goods, as the saying is. Usually tending to the side of leniency in the penal management of such persons, his results in correcting behavior were no better than those produced by punishment; and, of course, there were, in consequence of his methods, more criminals at large for longer periods to prey upon the public. A few of the less scrupulous practitioners also caused suspicion to fall on psychiatry, by their willingness to give medical evidence for the defense in court, when paid to do so, in cases of wealthy or influential people who had broken the law—when few if any bothered to go forward to give such evidence for the poor or friendless delinquent. Needless to say, such instances always received great publicity. These two factors probably accounted largely for a great revulsion in public opinion, which became rather hostile to the psychiatric approach for some time. This hostility has, however, died down considerably, because crime is still a big and growing problem, and so difficult of solution that no possible source of help is rejected.

The more recent psychiatric approach has been more judicious. It has been asserted that, on account of his training to deal with abnormal behavior, the psychiatric specialist is well qualified to investigate and carry out research into all aspects of crime, itself abnormal behavior, but that this does not imply his certain knowledge of cause and cure. The matter of criminality remains, therefore, primarily the domain of workers in the field of penal methods, and the psychiatrist is the technical adviser to such people. This is working rather well. Most prison medical officers now take their diplomas in psychological medicine either before or after entering the prison medical service. In addition most of the large prisons have visiting psychiatrists or psychoanalysts, full or part-time, investigating and trying out treatments of various kinds. Perhaps the most important center, however, is the Portman Clinic for the scientific study of delinquency. This has a rather large staff of psychiatrists carrying out a program of research. A good deal of

interest, but nothing as yet of what one might call decisive practical value, has emerged.

And now to say just a little about the general position with particular emphasis on mental hospital practice! This, after all, is the writer's main theater of activity. First of all, there is a very strong movement in England toward the structural betterment of all the hospitals. The management committees of all such institutions have awakened to the need of housing even the chronic or long-term patient in quarters more appropriate to a sick person than to "a pauper lunatic" as a patient used to be called. Old buildings are being altered, usually at great expense, to be made lighter, better decorated and more comfortably furnished. Instead of bare floors of stone or wood, walls painted in drab browns and greens, and rooms furnished with trestle tables and an inadequate number of benches, the wards or halls have linoleum, and often carpets, brightly painted or papered walls, and a sufficiency of really comfortable armchairs and small tables. Amenities in the form of cafeterias, club rooms, shops open much of the time for patients and their relatives, are found in an increasing number of places. More and more excursions by motor coach of all long-term patients, even relatively deteriorated ones, into the outside world are provided by nearly every hospital. Each has its coach for this purpose and uses it many days each week. In one or two hospitals it is even suggested that the chronic patient gets preference over the more recent recoverable case; and occasionally this may be so. The chronic patient in an English state hospital has for so long been the outcast, for which the bare minimum was done, that perhaps it is as well that there should be one or two fanatical pioneers in this field to accelerate a long-needed change.

This also illustrates another noticeable tendency. The resources in toto are limited in every hospital, so that in each one a decision seems to be made, either deliberately or not, to develop along one or two lines rather than to attempt progress in every direction. One institution will organize occupational therapy for example, employ large numbers of therapists and experiment with various forms or combinations: painting, or music, singly, or in groups. In such a hospital, one may find laboratory investigations being carried out to a minimal extent. Another hospital will push out along the direction of biochemical research and perhaps have few resources left to develop social services. A visitor to individual

places, therefore, may, on occasion, be surprised at the apparent neglect of some important service. Yet, at any rate, the situation is one in which discoveries can be made, and not one in which a general standard of sameness might shortly lead to a sterile lack of progress, especially now that medicine is nationalized.

The general shortage of beds has also tended to promote a movement to get patients out of the hospital as quickly as possible. Perhaps this goes a little too far in many places and results in an aim which is not really in the best interest of the patient or of psychiatry. That is to say, it often appears that the need to cure the patient is relegated to a secondary position, in the haste to get him out of the hospital at the earliest possible moment.

Another development that might be mentioned is the movement to interest some outside body to form a panel of "friends of the hospital." In its best form, when such friends are properly selected, this works well. Such friends will "adopt" a patient in the wartime meaning of the term, and endeavor to help him in some quite informal, friendly way; visiting him, inviting him home occasionally, perhaps for a week-end at times. Then if he leaves, they will help to find him work, or to find a social circle of acquaintances if he has a job. This activity is often most valuable in making a contribution, complementary to that of the psychiatric social worker, in that there can be a more intimate individual contact than with the social worker, and an absence of an official relationship that can sometimes hinder a patient's rehabilitation.

Last, in this connection, may be mentioned the slow but steady exteriorization or broadening of the psychiatrist's attitude. The writer knows of no mental hospital that does not now help to staff the out-patient department of a general hospital or clinic, private or otherwise; and yet, only a dozen or so years ago, less than half the English psychiatric hospitals would have come under this category. The effect on the psychiatrists has been most salutary. It has even cured one or two! Not only has it diminished the number of mental hospital doctors who had become completely nihilistic, therapeutically speaking, but it has produced a big change in the relationship between psychiatrists and doctors in other fields of medicine. A psychiatrist is looked upon less as one of a species of witchdoctor to be called upon only *in extremis*, and is now considered more often as one member of the medical team necessary to deal with the many aspects of a patient's health.

Although at first sight, this is rather an inconspicuous influence, the writer rates this development as one of the most important, and it is certainly widespread.

This completes the general survey pretty well. It is to be hoped that the material is not so diffuse as to be more confusing than revealing. As one can see, however, psychiatry and its organization in all the sub-branches are very much in the melting pot in Britain at present; and in some directions in particular, development is of a very tentative nature. In nearly every field, the call is for reliable methods of assessing the results of treatment; and no doubt these will be forthcoming in due course; but, until then, certain advancement is difficult to plan and carry out. A good deal of work is proceeding all the time, and it is not too much to hope both that reliable methods will be developed shortly, and that time and money will be made available to sift out good methods from bad ones.

II. IMPROVEMENTS IN PRACTICE, INCLUDING OPEN DOOR POLICY

A fresh if strong breeze has been blowing through British psychiatric circles during the last 12 years or so. It represents, in part, a popular and widespread demand, even if only vaguely expressed, and, in part, a movement from within the specialty, and in particular within the part of it concerned primarily with the established mental hospital. Needless to say—like the dust which wind sometimes blows up—much that is strange, odd or tiresome has appeared with this psychiatric breeze, but in the main it has stimulated a number of good ideas, some almost revolutionary in character. The New Mental Treatment Act, promised for 1959, the provisions for which have already been set out tentatively in a government white paper, reveals much of the public feeling in the matter.

It would be unprofitable to describe in detail the various suggestions made in this white paper as the precursor to the proposed Parliamentary act, but the general idea is simple enough. As far as possible, the aim is to initiate a state of affairs in which someone suffering from a mental illness will enter a psychiatric hospital without any formality, much as he would enter a general hospital for some medical or surgical condition. At the moment a patient enters either involuntarily under certificate, or after having signed a statement to signify his desire for admission on

the strict understanding that he may leave if he gives three days' notice. If he enters a general hospital he signs no such document. He takes it as a matter of course that his entrance is necessary and does not view the whole process as a matter of signing away his liberty on the understanding that he retains a right of leaving any time by giving 72 hours notice. This comparatively innocuous little formality distinguishes admission to a psychiatric hospital from any other kind of hospital in the United Kingdom, and although voluntary admission was a great advance in its day, it is felt that it is time to abolish the process, as it helps to keep up an invidious difference between general hospital and mental hospital. More than that, it has often acted as a weapon militating against a patient's recovery.

Give people a right, and a certain type of person will use it just to see that it is genuine. One person giving such notice in a ward, can bring up the matter in the minds of others who had never thought of leaving, and before one can turn around there may be a dozen insisting on their immediate departure, some of them in a phase of treatment that makes it dangerous for them to do so. A provision for the relatively few patients who will actively resist admission for treatment there will have to be; but it is hoped with some confidence that it will rarely be needed. There will be a change, therefore, to "You need hospital treatment and it will be arranged at once," from, "Will you agree to go for treatment? There will be safeguards, etc., etc." Most mental defectives will be similarly dealt with; but one weakness apparent in the proposals seems to be the implied suggestion in one section that all psychopaths in due course will be treated together, that is, the highly intelligent as well as the unstable moron, it having been fully recognized now that the moron needs care, more because of his psychopathy, than because of his dullness. The prospect of a highly intelligent antisocial psychopath having at his command, in the mental deficiency hospital, a number of equally psychopathic dullards to carry out whatever plans the master mind may decide, is one that seems too likely to occur, and is too dangerous to permit such an arrangement to go through unchallenged. A later section of the proposed act, on the other hand, can be interpreted as meaning that the psychopath will go to the mental hospital proper, so clarification is needed.

Further proposed steps include the discontinuance of giving official designations for hospitals, e.g., "mental," "mental deficiency," "tuberculosis," etc. There is provision of better, quicker and simpler steps that relatives may take if they object to the compulsory detention of a patient, with relatives to have the power of discharging any patient in a hospital unless he is detained for a criminal offense. In the cases where relatives are not empowered to discharge patients, mental health tribunals are to be set up to give each reasonable case independent investigation if the patient himself demands his discharge.

In addition, the whole subject of aftercare is thoroughly considered, and provision is made for it. Local authorities are to be required to supply various forms of aftercare, with trained social workers, social clubs, community occupational and recreational centers and the like. This should be particularly valuable for co-ordination of the whole activity, because, at present, the position is muddled. Over the last 20 or 30 years in every district a number of different bodies, some organized by national or local government departments, others by voluntary associations, have been trying to deal with aftercare, for the most part independently of one another. The most farcical results occur. A family may have been supervised by perhaps seven, eight or nine different bodies, and given support in treatment, money or material, by each one; and because there has been such a mix-up, the results on the whole have naturally been lamentable. A case was quoted in a meeting the writer attended some time ago of a family, who lived in a large city, and the case illustrates this point very well. Over something like 20 years, all the members of this family had been in contact with various social welfare departments, child guidance clinics, national assistance boards, probation officers, etc.; and, of course, the home had been visited and advice given by numerous other officials. In time devoted by these would-be helpers, material assistance in money and kind, and so on, it was estimated that over £23,000 had been spent on the family; and yet at the end of these efforts, the father was in jail, the mother in a mental hospital, one son in a mental defective colony, two sons at Borstals, one daughter also in a mental hospital, and two daughters prostitutes. It was added, for consolation one presumes, that whenever they were by chance united they were a very affectionate family, very loyal to one another! As can be seen there-

fore, it was time that something was done from above to co-ordinate all these well-meant efforts, and, in fact, several towns, including York, are already anticipating the act and beginning to operate good, comprehensive mental health organizations to co-ordinate all necessary services.

As the new act will also provide, most of these present mental health efforts link up the work done by hospitals and local authorities, so that when a patient in the hospital is fit to go home he has a decent home to go to, work to do, or a training center to attend, as well as suitable places to which he can go, with others like himself, to enjoy social or recreational activities. The aim is to give supervision, when necessary, by social workers who attend hospital conferences and know about the patient and his treatment before his discharge.

Now this is only the bare outline of the matter, but it does represent very big progress in the attitude of people toward psychiatric illness. Whether it is too much in advance of public opinion remains to be seen. The public, as always, wish to eat their cake and keep it. People will protest loudly at intervals about the alleged detention of some psychotic or defective, saying it is unnecessary, and yet protest as loudly a day later at the discharge of someone, apparently recovered, who then goes and commits some spectacular crime. There is no doubt, however, that even if modified by more cautious advisers, the final form of the act will emancipate the person suffering from psychotic illness from a good deal of the legal discrimination and prejudiced treatment he has suffered in the past.

This education of public opinion is a most important aspect of the matter, when one considers the corresponding changes in the management of patients within mental hospitals. Even when the State Medical Service began 10 years ago, most hospital management committees—each of which might have perhaps half a dozen hospitals of varied types under its control—would always spend most of their time and money on the general hospital. The mental hospital always came a poor last, and money spent to improve it was grudgingly provided. However, a change has rapidly occurred within the last two or three years, and the degree of mental hospital comfort has increased tremendously. With the one exception of overcrowding, which cannot be dealt with adequately until there is money to build new hospitals, things have changed dramatically

for the better. Large, forbidding and ill-lit buildings have in many cases been reconstructed to be more comfortable, to be lighter and to look less like prisons from the outside. The wards have been decorated in bright colors—with wallpaper, for example, where indicated—and not with the cheapest possible paint, usually a brown or khaki of the most depressing shade. The floors, instead of being bare boards or stone flags, have linoleum, rugs, and, in some rooms, carpets. The furniture is more like the kind of thing one finds in hotels, not the old heavy benches and trestle-type tables of scrubbed bare boards. The corridors from ward to ward—which used to be dark, brick-lined tunnels—have been lightened by making windows, plastering walls, painting and decorating, and putting coverings in pleasing colors on the concrete floors. Every hospital has its social club, nearly every one its canteen where soft drinks and snacks are available for patients and relatives.

Getting to the personal side, we find the attitude of the staff to the patient has changed appreciably, largely because the nurses who have come for postwar training are really of a different type than before. They are now nearly always men and women interested in nursing, whereas not so many years ago they were just manual workers looking for jobs. Up to about 1935, most public mental hospitals got nearly all their male nurses, or attendants as they were called, from the ranks of army reservists. The latter would serve seven years with the army and then be on reserve for seven years and so be looking for jobs. It is surprising that they turned out as well as they did, but, as might be expected, their manner was generally more that of a warden than a nurse. At all events, present-day nurses now do look upon their charges as sick people who are to be treated and who may recover in due course, not just as a collection of mad and dangerous folk to be guarded in custody until it becomes safe to release them, or until they die.

As well as the recruitment of nurses with a vocation (or calling) for the work, the introduction of specific treatment such as electric shock therapy and insulin coma therapy had no doubt a lot to do with this change. Life in a mental hospital, up to 1932 or so, was pretty easy to describe. The patients got up and had a meal. Then those who were fit to work went out to work in gangs with a nurse or two in attendance. Those who couldn't work were chased around the "airing court" for an hour or two, morning and

afternoon, or were allowed to wander around the ward dayroom if the weather was wet, while another handful of nurses watched to see that they didn't damage themselves, other patients or the property, more than could be helped. They went to bed early; and one night a week the better ones went to a dance, and one night to a cinema show. About the only innovation for some time had been more scientifically-organized occupational therapy which merely enabled some who were unfit to do heavy manual work, e.g., farm or laundry duties, to occupy themselves with handicrafts, instead of aimlessly wandering around the ward.

Life is a bit more imaginative now. On the wards for recent admissions, a fairly active treatment list is scheduled for most of the mornings. If a patient is not actually being treated, he attends occupational class, or does some kind of work on the ward. In the afternoons, he is similarly occupied; he plays some game, or attends a recreational activity such as country dancing; or perhaps he goes out with a visitor to a meal and a cinema show. If not well enough, for this, a patient may take a walk in the grounds with his relatives, and have tea in the hospital canteen. On the chronic wards, less treatment goes on, but it is by no means nonexistent. A fair number of patients in nearly every hospital have maintenance electric shock therapy, for example, to keep them well enough, week by week, to occupy themselves or to appreciate the hospital amenities to a greater extent than would otherwise be the case. Few of these, or of any others, go out in the old "chain gang" system to work on the land, in the kitchen or elsewhere. The proportion of salaried staff to patient labor is now overwhelmingly high in the various supply and maintenance departments of all hospitals. Patients who like gardening, cooking, or whatever it is, will naturally go and work where they wish, but the others will probably attend classes at occupational therapy centers.

The proportion of parole patients in all hospitals has risen considerably. When I began my training in a public mental hospital of what was then a fairly average type, I was given, according to old tradition, the chronic male block in that hospital, that is about eight wards, making a total of about 500 patients. Of roughly 60 patients in each ward, I doubt whether any one had more than three patients who enjoyed "garden parole." I think there was only one man among the lot who had parole outside the grounds. I

am certain no ward in the hospital now has less than 50 per cent of its patients enjoying freedom of the garden, and some wards will have virtually 100 per cent.

In the main it is fair to say that this liberty movement has worked. Escapes from hospital are only a little more common than before, and the number of antisocial acts, including suicide, committed by people who have escaped is not materially greater. It is difficult to obtain exact figures, but, as far as suicides are concerned, the York coroner told the writer recently that his figures show no appreciable increase in the suicide rate over the last twenty-odd years, during which time these changes have been taking place. The unusual case of an escaped patient committing a criminal offense, such as child murder, receives so much publicity in the press that, in the public mind, its incidence is generally believed to be much greater than it actually is. Most child-murders in the United Kingdom are, of course, cases of infanticide on the part of the mother; and they total only 20 or so a year. Each time a murder is traced to some ex-patient, however, with indignation whipped up in the newspapers, there are usually protest meetings and marches and petitions on the part of the various women's associations, townswomen's guilds, women's institutes, and so on, in the part of the country concerned. In actuality, the risk appears negligible, when one remembers that the number of children killed on the roads every month is very many times the number of all child-murders committed in a year. However, public opinion is, as one knows, a curiously influential force; and it is tactful to carry it with you when possible, rather than to be fanatically riding some hobbyhorse that always brings one into collision with such a potentially powerful opposition.

It is particularly apt to remember this, when going on to consider the subject to be raised, the open door policy. The writer does not know how much this movement has spread in the United States where as far as he knows, it may have already exceeded in degree the practice of the average British mental hospital. In the United Kingdom, there are now several hospitals with completely open door systems. Dr. Bell at Melrose, and Dr. D. MacMillan at Mapperly, Nottingham, are, without doubt, the pioneers, with their examples followed shortly afterward in modified form by Dr. T. P. Rees, who has recently retired from Warlingham Park Hospital, near Croydon. In the two hospitals first

mentioned every ward is unlocked from dawn till dusk, and patients are free to come and go without hindrance during those hours. In addition to the still-under-a-dozen places who have followed suit completely, nearly every hospital has, of course, greatly increased its number of open wards. But the whole subject will be gone into more closely.

When the completely open door hospital was first heard of, the writer must confess that he, for one, thought there was a trick about it, that a nurse was always placed in a good tactical position near the door, or that an efficient espionage, *à la Russe*, had been devised, using one patient to watch another. A colleague and the writer, therefore went around a number of hospitals, in particular Melrose in the Lowlands of Scotland, and Mapperly in Nottingham. Melrose serves a rather sparsely populated little county and has about 500 beds; Nottingham serves a closely-packed city and has 1,200 or so patients. It was found out that there was no trick about it at all. All the wards did have one open door; and in Melrose, where Dr. Bell had initiated the practice, he has all doors in the place unlocked with the exception of the door of the dispensary. Both the writer and his colleague decided on balance that it was good, but neither was convinced that having every ward in the place open was necessary to obtain maximum results, though on the other hand, judgment was suspended, as there was no proof at all to support the contrary possibility.

It was decided to open all the wards at The Retreat—gradually and steadily as the results seemed to justify the action. At present, The Retreat has gotten to the point of having eight wards open, one half-open and three still closed. Some of the reasons for these three still remaining closed are topographical; for example, a men's chronic disturbed ward has its only exit through a women's convalescent ward. The whole hospital is, therefore, being reconstructed, partly because it needs it, but primarily to enable re-organizing the wards and making them all open, if it is still felt right to do so. Both admission wards are now open, and most of the women's chronic disturbed ward. The male disturbed ward would be opened tomorrow, if there were only a proper exit to the outside without going through the women's ward.

There is one important modification at The Retreat, however, that Dr. Bell in particular would brand as heresy. Within a ward, there are short periods, say during insulin coma treatment in

the morning, when one of the larger rooms in which treatment is given is locked. It is felt as yet, that the risk of patients slipping away and dying in a coma somewhere before being found is an unjustifiable one to take. The purist open door advocates would reply that having one locked room ruins the whole conception—that is, that there is always “the room of the snake-pit” in a patient’s mind, to which the apprehensive patient may feel he may one day descend. There is undoubtedly something in this, and when the public is a little better educated, it may be necessary to take the risk mentioned, if the ideal of everyone having the same attitude toward a mental hospital as to a general one is to be achieved. However, the writer would wish to suspend judgment about this for a little time longer.

Now the advantages of open doors are truly many and great. There is no doubt that the patient-to-doctor and patient-to-nurse relationship alters considerably. The doctor and nurse are no longer the ones who hold the key to the door to freedom, literally and metaphorically. The open door does something—even to the patient who is not in the least paranoid—to make the patient’s co-operation more wholehearted. It is, too, much more pleasant of course for the patient himself, and particularly for his relatives, especially when he is admitted; because, as one knows, relatives are often seen to wince a little when the door is locked behind the patient. And it is good for the doctor, too; it lessens, if only by a fraction, that Jehovah-complex so many of us seem to develop when we have spent so many years talking to deluded patients, and so go on to presuming we must always be right.

The writer ranks this alteration in relationship as easily the most important result of the open door, but others follow. Reluctant or indecisive patients do agree to come in more easily. As one might expect, attempts to escape lessen very considerably indeed. The challenge of the locked door is not there any longer. The whole management of the patients in the hospital is affected. They do not have to be herded about or led individually by a member of the staff who has a key; but they learn their way about and can get to where they are wanted, be it doctor’s consulting room, psychologist’s office or anywhere else. They seem to develop more initiative when less regimentation is needed. They find it easier to run their own clubs, recreational and social. For this reason they seem to be more active, go to bed later, sleep better

and with less sedation. Dr. Bell would maintain that the open door is curative; but, except by its possible effect in uplifting the morale of those really chronic patients who have been locked up for years, one doubts whether this is materially the case. Perhaps Dr. Bell is a little overenthusiastic, as is only right and proper for a pioneer in the field.

On the debit side, there is also something to be said, as one might expect. First—and this applies to the large public hospitals rather than to the smaller private ones like The Retreat and the New York Hospital—Westchester Division—is the increased risks in the recent very disturbed admission. If a patient is in violent mania, or very actively suicidal, it would not be any more difficult in Westchester than it is at The Retreat, the writer would imagine, to have the patient nursed by special nurses for the time needed to observe and investigate fully. In the majority of state hospitals, however, this is not possible. With the risk of a suicidal woman running away and killing herself or of a violent patient committing some dangerously aggressive act, the practice in most of these open door hospitals seems to be to admit; treat at once with electric shock therapy, perhaps within an hour of admission; and keep treatment up until the patient quiets down. This, done before full investigation, is, as all admit, very bad medicine and a big disadvantage. Second, one must mention the nuisance of the open door to people who live nearby, and sometimes also to relatives. The persistent escaper is now infrequently seen; but a number just walk out a few days after admission, and they may keep on doing it. It is troublesome for relatives to find the patient unexpectedly at home and have to bring him back to the hospital, or to ring up the doctor to have him sent for. The police have also to be patient and co-operative, and are remarkably so in all areas known to the writer. When a large hospital has suddenly "gone open," the police force locally seems to spend half its time finding patients or chasing after them to bring them back. After a while, the position seems to stabilize. If the police were unsympathetic, it would create much greater difficulties than exist at present. The mildly-demented chronic patient, too, can be very much of a time-wasting nuisance locally by button-holing the local tradesmen, and going into shops and babbling away, perhaps for hours. It always amazes the writer to see how patient and kind

nearly all such townfolk almost invariably are. It is exceptional to find someone lodging anything like a complaint.

When The Retreat opened a long-term male ward a year or two back, one of the patients went into the local bank to see if he could be accommodated with some financial help to open up a large nursing home, which he estimated would cost rather a lot. He was, of course, ushered into the bank manager's office and even given a cigar. It was only when he mentioned that the sum he had in mind was £150 million and that the home was to be a maternity home for which he would import a couple of hundred of what he called breeding girls from Ireland, he himself apparently being the proposed father of all the expected children, that the bank manager inquired his present address. Although undoubtedly disappointed, the banker was most agreeable about the whole affair. Even when the man went down again two weeks later, the bank official was still very good about ringing The Retreat up to fetch him, something he did without the slightest show of ill temper, though of course he didn't waste any cigars on him the second time. In big ways and little ways, the public and especially the police seem to have gone a long way along the path of enlightenment, but the reader will know better than the writer whether the same would be the case in the United States.

The psychopath does, of course, present another big difficulty. Up to date, if a patient is committed by a magistrate to a state hospital, the superintendent has no right of refusal. All varieties of psychopaths, persistent razor blade swallowers, phony suicide cases, quarrelsome, antisocial and aggressive types, and of course the whole gamut of sex perverts and drug addicts, are sent in on certificate from time to time. Without exception, they walk out of an open door hospital as soon as their need for a bed, lodging or exhibitionism is satisfied. They will then frequently commit some crime or other, and the usual hue and cry arises in the press: "Mental patient bludgeons and robs old woman"—"Walked out of Open Door Hospital"—"Why should dangerous lunatics be allowed their freedom in this way?"—"Neglect on the part of psychiatrists"—and so on. This remains a problem and will continue to do so, the writer thinks, until separate and different institutions are built and maintained for psychopaths, or until the psychopath problem is solved otherwise. There is no doubt that, in some localities, unhappy experiences of this kind have caused the hos-

pital authorities to keep the wards locked because of the strength of local prejudice created by some incident of this kind. Almost without exception a psychopath not a psychotic is the cause of it.

One other type of illness also provides something of a puzzle. Certain insecure patients, paranoid perhaps, or feeling hunted because of some real or imaginary threat, do undoubtedly feel safer behind locked doors. Such people look upon the locked door as something to keep the enemy out rather than to lock the patients in. The writer had such a patient a year or two ago and he only told of it after he had recovered and had been home for some time. He showed his gratitude by remembering the hospital handsomely in his will. To estimate the proportion of such persons is difficult, but the writer believes they are not really numerous. However, it is one argument in the case for having at least a section of a ward closed, one consideration when weighing up the final decision as to how much, if not all, of the hospital is to be opened.

Of particular concern to a private hospital like the New York Hospital would perhaps be a mention of how the open door works comparatively, as between state and private hospitals in the United Kingdom. The writer thinks the difference is chiefly because, by and large, the private institutions have the successful businessman and professional folk to treat, whereas the public hospitals treat the manual worker predominantly. In the main, the private patient is more influential, and his doings in or out of hospital are greater news to the newspapermen; and he is likely to have greater effect on those around. Take, for example, the case of a businessman in fairly mild simple mania—the stage where he retains some limited self-control and yet where his judgment has just reached the crackpot stage where he will think any wildcat scheme a good one! Such a person may be difficult or impossible to certify and yet may have come into the hospital voluntarily and be too “busy” to think of giving notice to leave. He feels so fit, however, he will walk out of an open door hospital for a certainty and can then create havoc, even to the extent of ruining his business and family, before his illness progresses to the point where he can legally be put away. Again take the psychopathic relative of wealthy people, the man who usually has made a pretty fair mess of everything he has touched before his parents think of allowing him to be coerced or wheedled into entering a mental hospital. Once he is there, the relatives don't think

it at all funny, if next evening, returning home from bridge, they find the unloved one back under the parental roof—unexpected and unwanted. One is faced with the alternative of refusing to accept such a person, or keeping at least a part of the hospital locked so that such a person can be kept more securely. If one chooses the former, where is this person to go? Is it fair to give the relatives no help at all in their trials with a really unpleasant psychopathic patient who is making everybody's life unbearable in one way or another? A middle path is steered at The Retreat where such patients are accepted when it is felt that it would be cruel not to help, but are refused otherwise. If such patients are accepted, they are kept in a locked ward, and, frankly, it has not been decided what to do if and when the whole hospital is open.

The risk of claims for damages is, paradoxically, less real in private than in state practice. If the playboy son of wealthy parents creates havoc, or the rich widow drowns herself, the desire to keep dark what is considered the disgrace to the family, that a member of it has ever entered a mental hospital, overrides cupidity nearly every time. In a state hospital this is not so, and nationalized medicine is already doling out appreciable sums in settlement of claims made by patients under one pretext or another. On the other hand, a private hospital stands to lose more in another way. When no damage has been done, the irate parent can only bring back a runaway to a state hospital and more or less offensively indicate his opinion of the staff's ineptitude. He may write to the committee or his M.P., but his complaint will get nowhere, because as a branch of the civil service, the state hospital now shares in this relative inaccessibility common to all the civil service. Unless some serious incident has occurred, a letter is politely acknowledged about three months after it is sent, action is promised in due course, and one hears no more about it. But, and this is important, the patient of a state hospital cannot be taken anywhere else. It is the hospital in the catchment area in which the patient lives. In private work, hospitals are dependent on their clients. The Retreat's endowment funds are virtually nil. The hospital has to pay its way as it goes along and, therefore, cannot afford to lose too many possible patients. A patient who runs away in the first week or so—and this is the really dangerous period for runaways—is rarely brought back.

He is usually taken to another private hospital if care at home is impossible.

Largely, the writer thinks, the problem is a matter of educating the public to take the risk of inconvenience for the sake of freedom in the mental hospital. The public is, however, in some ways slow to learn. Recently, the writer admitted the wife of a baronet. As formalities were discussed, the husband commented on the fact that The Retreat was not an entirely open hospital "like St. Virginia's." The writer said, "Why then, Sir Henry, have you removed your wife from St. Virginia's?" "Gross negligence," he replied, "they found her in the grounds with her ankle broken and no one could say how it happened." The old human weakness, of course; people still want it both ways, open door and yet guaranteed supervision. The practical point remains, a private hospital can reckon on losing a certain number of patients; if such a hospital is entirely open, the patients who do run away are rarely returned.

How did one go about it? The Retreat always did have more open wards than most places in England; but, in the others, the tradition of generations had to be broken. It was interesting to compare the recipes for success given respectively at Melrose and Nottingham. In the former, it was learned, Dr. Bell explained the whole system to the staff, decided on a D-day and then opened everything. Dr. MacMillan, on the other hand, said he acted gradually, would talk it over with the sister of one ward, encourage, wheedle and then open that particular department. Once this was achieved, he would start working on the next objective, another ward—a gradual process of evolution in fact. Dr. MacMillan in Nottingham again emphasized the importance of providing plenty of occupation and recreation so that the patients had no time to think of running away. Dr. Bell seemed to consider this unimportant; for occupational therapy was, the writer would say, perhaps less developed at Melrose than in the average British mental hospital. "Let them go out and find what they want to do, mix with the public and feel part of it; that's the way to recovery—this was what he seemed to say. Well, it is a point of view, but once again the writer would mention the fact that it frequently makes demands of patience and long-suffering on citizens and business folk living within a few miles of the hospital.

At The Retreat, the gradual method was chosen. Hardest to convince that a runaway was no longer the responsibility of the nurse, but of the doctor and, in particular, of the medical superintendent at that, were the very senior charge nurses. It was hard for a sister of, say, 15, to 20 years' standing to change her outlook and realize that one of her cardinal rules had now become inoperative. With these nurses, one had to work slowly, opening the wards for certain hours and then extending the time slowly. In the younger members there was less reluctance to try; and, in fact, in one case a sister came up to the writer to say, "All the other hospitals are opening their wards, isn't it time I had my ward opened?" She was allowed to do it that day. The writer personally thinks that increasing the tempo of occupational therapy is important, if only to spare the local citizens hours of boredom by one's chronic inmates. In all, however, the writer would say that it is surprising how little and few are the modifications necessary. One finds that the long-term patients, senile or demented, are so used to the narrow world in which they live, real or unreal, that few bother to extend their usual round of walking, far beyond the ward. Most of those who do, do it gradually. The recently admitted senile case is a bit of a risk. An old woman, not yet habituated to the narrow confines of her ward and garden, tends to wander away rather than run away. The senile wards are The Retreat's biggest problem and one not completely solved as yet.

To summarize, the writer personally feels very grateful to Drs. Bell and MacMillan. He feels that they have made us think about a most important matter, and it has come to be realized that we kept far too much of the hospital locked up out of sheer force of habit. The writer feels sure that in England most of any hospital can safely be open. Whether as yet the public is sufficiently educated for all hospitals to be entirely open, seems doubtful. The writer also still doubts the assertion that having one observation section in a ward would decisively militate seriously against the aim everybody has in view, teaching the populace that a psychiatric hospital and admission into one are exactly the same things as a general hospital and admission thereinto.

And now, just a few words about certain other developments in the management of patients. There is the evolution of day hospitals and night hospitals. They arose in response to different demands and must be discussed separately. The old cry of bed-

shortage gave rise to the day hospital. This is merely a large house with living, dining and occupational rooms, and in most cases treatment centers as well. The patients arrive in the morning, either by themselves, or, if incapable, brought by relatives. In some instances, they are fetched from home by a hospital car. During the day the patients undergo whatever treatment is indicated: electric shock therapy, modified insulin (in some cases), or psychotherapy, besides possible occupational therapy, painting therapy, group therapy and the like. In the evening, the patients depart once more. If the patients looked after are senile, and some day hospitals are devoted entirely to cases of senile dementia, a coach again brings them in each morning. This enables the grown-up children of the patients to go to work, and to live relatively unhampered social existences until evening when the coach takes the old persons home and the relatives are then responsible for them overnight. Although the day hospitals were developed, as was said, because it was impossible to find sufficient existing hospitals for all cases needing accommodation, the use of day hospitals is extending rather appreciably. Many people like to get back to their own homes and beds at night. Many will agree to come for treatment, on such an understanding, who would not come otherwise. Whether the results are as good as for full-time, in-patient treatment, the writer cannot say. No reliable follow-up figures are as yet available. From the check-up at The Retreat, admittedly rough and for a small number, comparing patients treated by electric shock therapy as in-patients with the same number treated as out-patients, such a conclusion seems very doubtful, and more evidence would be welcome; for the figures seemed to prove conclusively that in-patient treatment on the average gave infinitely better results.

The night hospital serves a different purpose. Specific treatment of various kinds, when applied to really chronic patients, has often produced rather remarkable results. Facing the outside world, however, was often too frightening a prospect for many of the really improved patients, with such aftercare assistance as was available, especially if the patient lacked relatives and had been out of the world for several years. No one could persuade these patients to depart willingly; and if they did leave, the strain of everyday life and the loss of support given by the hospital proved too much for some, and relapses came only too

often. The development of night hospitals came as something of a step in the rehabilitation of such persons. The hospital building is usually the villa or a separate block of an established hospital. The patients are men and women who—after breakfast in the hospital—go out into the town and do a job of work like any other citizen. In the evening they come home and have a meal some time after 6:00 p.m. Thereafter, they enjoy the social and recreational amenities provided by the hospital, or if they please, go out instead. There is usually a fairly strict time for locking the doors and for lights out; but the place can be very economical in nursing personnel. In time, many night hospital patients make friends again in the outside world, and find lodgings or a home elsewhere—so that the scheme helps rehabilitation appreciably. At The Retreat, there is no separate night hospital at present, but a rehabilitation scheme is run on somewhat similar lines. The patient, however, simply occupies a bed in one of the convalescent wards, until he is sufficiently stable to depart finally.

These are some of the aspects of present-day practice in British psychiatric hospitals that the writer has felt could be mentioned under the term of general management. It is not pretended that the subject has been covered in every direction.

The Retreat
York, England

COMPARISON OF LOW AND HIGH DOSAGE PROCEDURES IN CHLORPROMAZINE THERAPY*

BY BURTRUM C. SCHIELE, M.D., ROY M. MENDELSON, M.D.,
ALLEN S. PENMAN, Ph.D., AND WILLIAM SCHOFIELD, Ph.D.

Although it is generally agreed that chlorpromazine is effective in the treatment of psychiatric patients, there is considerable uncertainty about procedure to obtain the most effective dosage. Some workers feel that the most effective dosages are high ones, particularly if the amount of medication is increased rapidly. Others hold that lower dosages are just as efficacious, less risky, and less costly. Recently, the authors have had an opportunity to make some approximate comparisons of the high and low dosage regimes.

For purposes of comparison, the "high" dosage procedure has been arbitrarily defined as dosages from 1,400 to 3,000 mg. daily, with the amount elevated rapidly. "Low" dosage was defined as 1,400 mg. or less daily, with the amount built up slowly. The "low" dosage level of 1,400 mg. or less was chosen, since several of the 38 patients studied in this paper had received chlorpromazine in amounts from 50 to 400 mg. daily on an earlier occasion and had shown no response. In addition, the writers had seen many other chronic schizophrenic patients, similar to the patients in their group, who had been treated with chlorpromazine, receiving dosages which the writers felt were inadequate. Therefore, while a comparison of the high and low dosage procedures was desired, the writers wanted, in both cases, to give what they felt was adequate treatment.

This study was conducted at the Veterans Administration Hospital, St. Cloud, Minn. The patients were all chronic schizophrenics, either disturbed or regressed. They were patients who had not responded to former types of treatment, such as electric shock, insulin, total push programs of various kinds, and forms of interpersonal therapy. Nine had had lobotomies. For a median of 40 months before the study, they had failed to show any improvement whatever and had remained at a somewhat stabilized level of adjustment. This type of patient was deliberately selected, as

*From the Veterans Administration Hospital, St. Cloud, Minn.

he offers the greatest challenge to the effectiveness of any treatment procedure.

Thirty-eight such chronic schizophrenics, the entire population of one ward, were carefully divided into two matched groups of 19 each. One group was treated with high dosages of chlorpromazine, while the second received identical-appearing placebos, for a four-month period. The early phase of this study has been reported in detail.* An attempt was made, in prescribing the chlorpromazine, to meet individual tolerances and needs. The manner in which it was administered, however, tended to follow a pattern, which consisted of rapidly increasing the medication until a maximum of 3,000 mg. a day was reached. After three weeks on this high dosage, the amount was gradually decreased to a maintenance level varying from 400 to 600 mg. a day. The high dosage patients have remained on maintenance amounts of chlorpromazine to this writing (May 1, 1957), a period of 16 months.

During the last 12 months of this period, the former control group was also placed on chlorpromazine. The intention was to prescribe medication for this group with a lower dosage pattern, so that comparisons might be attempted. These patients had their dosages increased, much more gradually than in the other group, to a maximum of 1,400 mg. a day, reaching that level after five months. They continued on this amount for approximately four months, when the dosage began to be gradually decreased to a maintenance level of 400 to 600 mg. a day. As with the high dose group, the medication was prescribed in an attempt to meet the individual needs and tolerances of the patient. Thus, if a patient began to respond on only 600 mg. a day, he did not receive more. Four of the patients who had failed to respond after six months on up to 1,400 mg. then had rapid increases to 3,000 mg. a day for three weeks—to see if they would respond to this more intensive treatment.

Other than the difference in dosage schedule, the patients in the second group were treated like those who had had high dosages. That is, they had a full activity program and the opportunity to consult trained personnel upon request.

*Mendelson, Roy M.; Penman, Allen S., and Schiele, Burtrum C.: Massive chlorpromazine therapy: The nature of behavioral changes. *PSYCHIAT. QUART.*, 33:1, 55-76, January 1959.

RESULTS

The results in the two groups are compared in the table of clinical results.

	Clinical Results	
	Number of Patients	
	"High" Dose	"Low" Dose
1. Attaining extramural adjustment	6*	2
2. On "privilege" ward	2	2
3. Assuming responsibility and maintaining integrated behavior	3	1
4. Showing integrated behavior with supervision ...	5	5
5. Making marginal closed ward adjustment	2	2
6. Showing no improvement whatever	0	6
7. Lost from study	1	1
	19	19

*Two were rehospitalized: One relapsed after medication was temporarily discontinued, and one returned voluntarily.

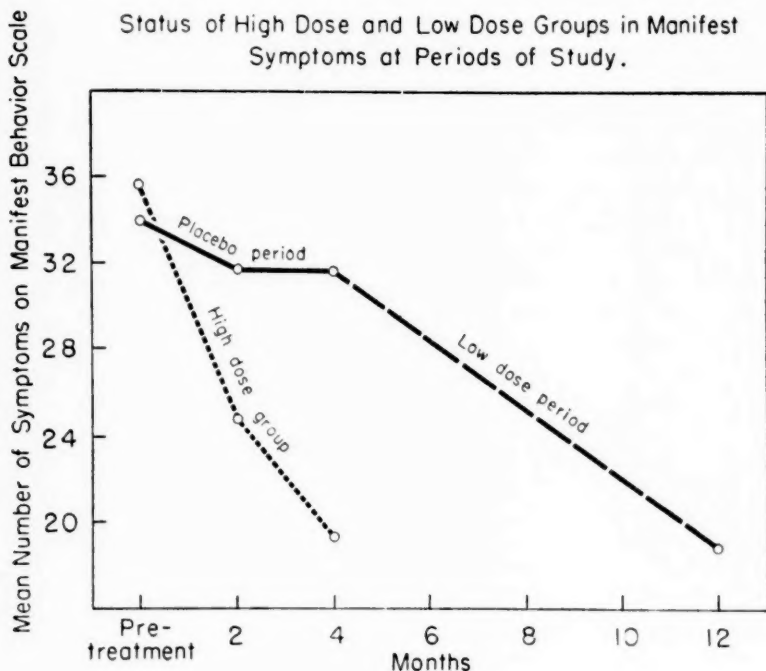
Of the six patients of the high dose group who returned home, four are working and making an excellent adjustment outside the hospital. One had his medication discontinued at the tenth month by a physician not aware of the study. This was one month before the patient left the hospital. He maintained his improvement for a time, but, after three months at home, was again acutely psychotic, disorganized, and hallucinated. He was returned to the hospital, treated with chlorpromazine in high dosages and again had an excellent response. He has maintained his improvement a month. Another patient returned voluntarily, saying that he had discovered that he just wasn't capable of maintaining himself without the supervision and security he had in the hospital. He has continued to make an excellent intramural adjustment on a "semi-privilege" ward.

Two patients in the low dosage group left the hospital; one is working and making an excellent adjustment; the other is not working but has been able to occupy his time by going to the library, doing some art work and attending church. He appears to be making a better adjustment outside than he did in the hospital. Of the two low dosage patients who went to the open ward, one relapsed shortly after his medication was discontinued at the sixth month. He again became delusional, hallucinated and confused. When chlorpromazine was given again in the ninth month,

he showed a prompt and excellent response. At the present time, he is on a semi-privileged ward making an excellent adjustment which he has maintained for a month to date.

Perhaps the most striking difference between the two groups was in the physiological "shock" that the patients who were receiving higher dosages experienced. Among the patients receiving lower dosages, there were no instances noted where the patients experienced marked physiological reactions, with concomitant psychological effects. There were six patients in this group, however, who showed no response whatsoever, at any time during treatment, either of a physiological nature or in behavior and thought processes. All patients of the high dosage group showed considerable improvement at one time or another. Months later, several of these patients regressed considerably from their peaks of improvement; but all of them retained improvement to some degree.

The Manifest Behavior Scales, which had been given on three



occasions to both groups between January and April 1956, were repeated on the low dosage group in December 1956. The results of these are seen in Figure 1, which provides comparative data for the high dosage group during the initial phase of the study. It may be noted that after eight months the low dosage patients showed a level of relative freedom from manifest symptomatology essentially the same as that achieved by the high dosage group in only four months.

Side Reactions

Since the side reactions in the high dosage group have been described in detail in another communication,* the ones following are those occurring in the low dosage group, except where otherwise indicated.

1. *Extrapyramidal Motor Phenomena.* These phenomena, including mask-like facies, rigidity, and tremors, were observed in six patients. In all cases, these symptoms were relieved by the use of cogentin, 4 to 6 mg. per day.

2. *Seizures.* Two patients had seizures. In one case these occurred at the level of 1,400 mg. a day; however, when the dosage was decreased by 200 mg., this patient had no further seizures. The other case occurred in a patient who was on 600 mg. a day. The medication was decreased to 200 mg. a day, but the patient had two more seizures. At this point, the chlorpromazine was discontinued, and he was placed on dilantin. He had already been on chlorpromazine for six months. He has continued to do well, although he has not had any chlorpromazine for six months.

3. *Toxicity.* Eight patients showed general signs of mild toxicity, such as unsteady gait, wooden expression, and excessive drowsiness. All these symptoms disappeared when the dosage was decreased to below 800 mg. a day.

4. *Vomiting.* There were two patients who developed persistent vomiting at 1,400 mg. a day. For one of these, the medication was discontinued for two months. During this time, no organic explanation became apparent for his vomiting; and he was again placed on chlorpromazine at the same dosage level, with no recurrence of symptoms. The other patient was on the drug for nine months before he developed vomiting. An esophageal stricture was discovered, and the patient was transferred to another hospital for 10 weeks for the treatment of this condition. He has now returned to the psychiatric service and is again on a small dosage

*Op. cit.

of chlorpromazine, without having further difficulty. (He is in group 5 in the table.)

5. *Bile in Urine.* There were two patients who had bile in their urine intermittently, according to the "Ictotest." There were no cases of jaundice noticed.

6. *Skin Reactions.* There were three mild skin reactions, all of which responded favorably to benadryl.

7. *Blurred Vision.* Five patients complained of blurred vision. They all developed this symptom after having received medication for several months. It was also found that there were eight patients in the high dosage group who had developed similar symptomatology. In all of them, the blurring lasted for periods of six weeks to five months, but finally disappeared in all cases.

8. *Dizziness.* After having been on the medication six or seven months, two patients in the low dosage group complained of dizziness; this was more marked with changing position, although no blood pressure changes were noted. One patient in the high dosage group had similar symptomatology.

9. *Photosensitivity.* All the patients in both groups, when exposed to sunlight, developed an excessive reaction in degree of sunburn, along with itching. This had been noted before, when the patients were out in the sun one year previously, and all subsequently tanned and had no further difficulty.

DISCUSSION

Although the two groups were carefully matched clinically, a completely satisfactory comparison cannot be made as one group was treated first with high dosages of chlorpromazine, while the other group received placebos before getting the drug. Four months later the second group was started—with a different dosage schedule from the first—on the active medication. It is possible that some of the differences in responses may have been caused by this difference in handling. Keeping this in mind, the following points can be made:

1. The dramatic physiological effects obtained in the first group were not present to any large degree in the second group. The writers felt that this was, in part, due to the slow build-up of the dosage. It appeared to them that the physiological "shock" could be an important factor in the efficacy of this type of therapy. This was one of the significant differences between the two methods of administration. With the high dosage procedure, each patient

had at least a temporary period of good response at some point in the treatment. This was not true of the slower build-up, lower dosage procedure.

2. Fewer good results were obtained with the low dosage group. The question is often raised as to whether a patient who has failed to respond in a lower dosage range will improve if a higher dose is given. The writers' experience is too limited to allow more than a very tentative suggestion that there are perhaps some patients who will respond to the higher dosage regime.

3. If the patient has not responded favorably after as much as five months on doses of over 1,000 mg. a day, subsequent elevation of the dosage is not likely to improve his condition.

4. In this particular study, the patients on the low dosage regime received—over a year—a greater total of chlorpromazine (305,000 mg., as compared to 230,000 mg.) than did the patients on the high dosage regime. This point might serve to show that the rapid, high dosage pattern is not necessarily the more expensive.

5. From another point of view, one could conclude from the data of the present paper that if a patient can respond favorably to chlorpromazine therapy, he is likely to respond regardless of dosage. This is true, at least within the range of the dosage used in this study. This point does not necessarily argue against the fact that the more rapid build-up procedure is still the more efficacious.

6. With chronic schizophrenics—who made up both groups of patients—it appears that the best results require medication over a period of many months. Chronic cases are especially prone to relapse, if the medication is discontinued.

7. It is difficult to determine what an adequate trial period is. There were several patients who did not give clear clinical evidence of favorable response until they had been on the medication for over four months.

8. The efficacy of drug treatment procedure is closely related to the other forms of therapy utilized in the treatment of the patient. The writers wish to emphasize that the medication enables the patient to participate in activities, to become more active

and to gain more satisfaction from his environment. However, medication alone is usually not sufficient, especially in chronic cases, to bring about lasting improvement. In both groups of patients reported in this paper, those who responded favorably were much more receptive to interpersonal contacts and to available therapy procedures, but they did not usually initiate such contacts.

Veterans Administration Hospital
St. Cloud, Minn.

VALUE OF GROUP PSYCHOTHERAPY IN PATIENTS WITH "POLYSURGERY ADDICTION"*

BY SELWYN BRODY, M.D.

Although frequency may be considered the chief determinant, the history of chronic readiness for and susceptibility to the operation—"mania" would constitute the "addiction to surgery" syndrome. The surgical habit can be almost a lifelong pattern, and the polysurgery patient is recognized in medicine as an extremely complex, baffling and challenging problem. In fact, it was the gravely-expressed concern of the Lenox Hill Hospital** surgical service which was confronted by these patients that encouraged the author to pursue this study.

No sharp issue is made here as to whether surgery was performed with or without pathological tissue changes. The problem of polysurgery is hardly limited to the occurrence of palpably unnecessary operations. The emotional factors are of as great importance in the organic disorders leading to polysurgery.

Among the consistent findings of chronic self-damaging processes in the polysurgery patient, is an endless pursuit of "peace of mind," which would include an almost "psychotic" elimination of problems and anxiety. This infantile, irrational search is predicated on a naïve, magical belief in surgery, which becomes associated with a passive "mania" for surgery. This state of mind readily victimizes and subjects such patients to the active counterpart of their passivity—surgery. The symptoms leading to surgery—and the mania for operation—express an infantile cry for care and attention, for which these patients feel starved. The mechanism of self-sacrifice in their ego and character structures is reflected in their impulsive submission to surgery. It is derived from the need to placate and surrender to important family figures.

In this paper many of the characteristics of the polysurgery patients observed by previous psychoanalytic¹ and psychiatric investigators were evidenced by behavior in the group therapeutic

*From the Lenox Hill Hospital department of neuropsychiatry. Presented at the American Psychiatric Association 113th Annual Meeting, May 13, 1957, Chicago, and also, in abbreviated form, at the American Group Psychotherapy Association 14th Annual Conference, New York, January 11, 1957.

**New York City.

process. It will be shown how these patients made destructive efforts to break up the group, as well as attempting to keep together and build the group. The point which the author wishes to convey concerns the various disadvantages and negative aspects, together with the advantages and positive aspects, of group psychotherapy with such patients.

As far as the writer can determine, this is the first study reported of group psychotherapy on the problem of surgery addiction. There was moderate, general improvement in these patients and a reduction in the polysurgery trend. A process of therapy was seen to counteract and replace the surgery addiction, as manifested in the group situation.

Preliminary observations were made on three adult female patients who had a combined total of 18 major and minor operations for removal of, or upon, various organs and parts of their bodies. The material was selected from one and one-half hourly group psychotherapy sessions, based on psychoanalytic principles, held weekly for more than three years, from March 1955 until July 1958. The request to patients to express and communicate their feelings and thoughts took the form of a free association to their symptoms. They were also asked to give past and present emotional material on their life situations. Expression of attitudes, both negative and positive, toward the group therapy and the therapist was encouraged. Sexual and dream material, as well as reports on childhood history, were significant in their paucity.

The aim in the early phase of the group was to reinforce the patients' fragile defenses in their need for help and release. Only a minimum of testing and interpretation was indicated. The primary task was to create a therapeutic atmosphere in which these patients, with their marked ego debility, could be encouraged to function to their maximum.

Throughout the sessions, material was disclosed suggesting that the patients' somatic and organic symptomatology was basically related to narcissistic and pre-genital conversion mechanisms, traced back to pre-ego and pre-verbal phases of personality development.

THE PATIENTS

The three patients were: Mrs. B., 49, with 10 operations, and 17 hospital admissions; Mrs. C., 43, with a history of five operations; and Mrs. E., 59, with three operations.

Mrs. B.

Mrs. B. had been ill, physically and emotionally, for at least 30 years. Her chief physical sickness had been pulmonary tuberculosis, for which she had had three thoracoplasties. Her latest illness was colitis. She is married and has one child, a son, 27. She, too, is an only child. The patient tries to gloss over her early childhood and family life as being most happy. She actually had a very difficult childhood relationship with her mother. She said, "No matter what I did, she never let me, and I always wanted to do things my way, but always I was wrong."

She was the only child of Hungarian parents who emigrated to the United States when she was an adolescent. Upon arrival in New York her mother opposed her dressing "like American girls, as indecent." She made her have an escort every time she went out. Her father was not brought into the story at all. Indeed, he was only mentioned at the time of his illness and death at the age of 81, late in the course of the group psychotherapy.

She finished high school and described herself as high-spirited, gay and interested in dancing, and other social-cultural activities. She has aspirations to write professionally.

While the patient tried to attribute all her illness and troubles to her "bad marriage," her husband's personality and his economic failure, the hospital record showed that she had had her first pneumothorax in 1927, nearly three years before her marriage. She blamed the marriage itself on her parents, who "made" her marry, even though she "hardly knew" the man. When she became pregnant immediately, she says an abortion was advised because of the tuberculosis, but she refused. Her mother died of cancer shortly after the patient's child was born. Her husband's inability to hold a job during the 1932 depression forced them on relief. Her hostility and clash with him reached the breaking point, but it was his own admission to her that he was a "failure" that she took as a last straw. It was then that she suffered a pulmonary hemorrhage and had to spend the next three years in a sanatorium. The child was placed in a foster home.

Even though the tuberculosis was arrested for several years, she was in and out of hospital wards and clinics with various ills. In 1950, there was a reactivation of the tuberculosis and she had the first of three thoracoplasties. The patient had been an invalid up to the time of the group therapy, maintaining the

barest minimum of household duties, with an almost total absence of social contacts. She had been seen by both private and clinic psychiatrists, as far back as 1939, but always broke off the contacts. Their observations included this comment:

Intense anger, ambivalence and hatred of her husband, which she refused to believe. The marital tension and the tuberculosis were interrelated and she used her tuberculosis to influence her husband. She smoked incessantly and defiantly—even "if it shortened her life"—as a gesture of independence toward her husband and father. When symptom relief and improved relationship with her husband had occurred as a result of the ventilation of her problems to her psychiatrist, the patient broke off treatment, and a few months later suffered a pulmonary hemorrhage. But the patient showed no interest and desire to get better, owing to her hostility to her husband. She would not welcome any suggestions from any psychiatrist unless they agreed with her own. She made a serious suicidal attempt with an overdose of barbiturates in 1952 after her husband declared he did not want her any more.

It was after a "showdown" with her son, who was about to be ordained a minister, that she made a "pact" with him to get psychiatric treatment, which led to her membership in the author's group. When first interviewed for admission to the group she looked cadaverous, and weighed about 90 pounds, although she was of average height and development. It would be difficult to imagine a more debilitated, yet ambulatory, patient attending a group session. She looked like a scarecrow. She seemed hardly able to make it to her various clinic appointments, including the group session. She would settle into the only soft chair available, which the others learned to reserve for her. Her speech was thick, not so much because of her guttural accent, but from the influence of barbiturates and tranquilizers. She complained of her physical condition and years of invalidism. She agreed to attend group sessions while saying she would not tell her problems in front of others.

Diagnostic Formulations. The material indicated an extremely severe personality disturbance extending back to childhood. Despite a brittle defense of outward sophistication, aided by superior intelligence and verbal facility, she was basically hostile, critical and sarcastic. She was extremely demanding and controlling, unable to tolerate anything but agreement. She was so hypersensitive to criticism that upon the last word of disagreement, her "world falls in on her," an apt description found in a

strikingly similar case of tuberculosis reported by Weiss and English.²

This pathetic patient wanted love desperately, at the most infantile level. The frustration of her unrealizable demands caused her extreme agony and bitterness. She tried to defend herself against this by her transparently provocative quarrelsomeness.

Mrs. B.'s grasp of reality and her ego equilibrium were precariously dominated by her painful conflicts. With extreme blindness, she projected her difficulties onto external figures. Clinically she was regarded as suffering from a schizophrenic reaction, paranoid type, although the psychology tests also suggested "severe neurotic depression in a schizoid personality."

Mrs. C.

Mrs. C. is a 43-year-old married woman, with a history of five operations. She had been referred for psychotherapy after years of failure of medical and surgical treatment. Her private internist had scolded her for "getting unnecessary operations." She is Jewish, is the oldest of three children, and emigrated from Europe with her family at the age of 12. Her earliest memories in Europe are decidedly traumatic. After her father had announced that her mother's three brothers had been killed in a pogrom and his own property confiscated, the family fled to Canada. The father never managed to regain a business position anywhere comparable to that he had had in the old country and was reduced to the status of a peddler. The patient said he lived in a dream world, recalling past glories, which was more than depressing to the other members of the family. The mother developed a serious thyroid disease and died at the age of 52, when the patient was 30.

The patient had been a quiet, obedient child of average intelligence. She barely finished grammar school and went to work. She said that she played the piano so well "by ear" that instruction was recommended, but her family could not afford it.

She had married the only man with whom she had ever had a date, "because he was gentle and considerate." However, she attributed most of her difficulties to her marriage, and to the pace and tempo of New York, where the couple had moved. She was unable to persuade her husband to relocate in Canada, where she believed there "would be no problems." To the social worker, she had hinted at dissatisfaction with sex, but would not go into

details. Although the patient is extremely shy, sweet, courteous and conforming, she has been rigidly stubborn in opposing requests or suggestions to communicate material other than her somatic complaints. She admitted that "speaking up" had been a difficulty since childhood. She described her mother as being fearful of "talking out."

Mrs. C. said that her mother had *concealed* her last pregnancy and that when a boy was born the patient was "shocked" and would not look at the infant for the first week, then resumed her "good behavior" and became most attentive to him. She was 15 years old at the time.

In appearance, she is neat and trim, but inclined to plumpness. Her tenseness and bashful timidity, her naïveté and the clinging to organicity tended to make her seem nondescript and unanimated. (She produced the kind of dull, repetitious material which tries the patience of any psychiatrist.)

Since her marriage—for the past 10 years—the patient's life had been a never-ending round of clinics and doctors in the search for "something organic they can't find."

Diagnostic Formulations. Diagnostic consideration by the staff ranged from a psychophysiologic gastro-intestinal disorder to a psychoneurotic disorder with a latent psychotic reaction. This patient and her family had been the victims of traumatic emotional stress, profoundly affecting her personality development. Her ego functions were almost completely dominated by the need for rigid defenses against psychic stimulation. Her deficiency in expressing her feelings generated constant tension, manifested in her various visceral disturbances. She also used illness as a secondary gain to control relationships from making demands on her. She has never been pregnant.

She, too, reluctantly accepted group psychotherapy with the admonition that she probably would be unable to talk in a group.

Mrs. E.

Mrs. E., 59, with three operations, was referred from the medical service, where a complete check-up revealed diverticulitis and a basal metabolic rate of -13 , but these were regarded as insufficient explanations for her many physical symptoms. The diagnosis was "psychophysiological gastro-intestinal reaction." While the patient would say that all her difficulties were due to

the hard life she had led, she simultaneously stated that there was no connection between the emotional and somatic symptomatology. There was a vague history of rheumatoid arthritis and hypothyroidism.

Mrs. E. had been the oldest child in a family of low economic status. She had had a very deprived childhood, with her mother "never a year without being pregnant." The last pregnancy carried to term resulted in an 18-pound boy who died at birth. The mother, herself, was dead of cancer six months afterward at the age of 35. The patient was then 12. She had to stop grade school, to "mother" the two younger children and also had to go to work to help the family income. This was one of the many heavy burdens of her life of which she constantly complained.

Although she was born in this country, her father was German and "demanded only work and duty." He remarried within a year of the mother's death, and the stepmother was "not at all affectionate," nor was her daughter, the patient's new stepsister. (She later made the same kind of complaints against her mother-in-law.)

The patient was married at 23 to a man who had "slavish expectations of a wife," and who wanted her "more as a mother." He, too, was "German, and bullying, like my father." She said he wanted to "martyr" her, just as her mother had been martyred to a German husband. He also was too serious and was very immature, particularly sexually, and they both were "inexperienced and unprepared" for marriage.

Mrs. E. had become pregnant immediately, and she gave birth to her only child, a son. She would not have more children because she developed a navel hernia "from doing all the heavy work with the baby and no help."

The son was stricken with rheumatic fever at three and a half, and the patient dated her first symptoms of arthritis from this time. The boy contracted subacute bacterial endocarditis years later; and the biggest shock of the patient's life came when she was told that her 20-year-old son was going to die. When he succumbed in 1944, Mrs. E. was 48, and "the bottom dropped out of everything." He had been the "joy of her life," and she has been unable to fill the void left by his death. Her only interest has been symptoms and illness.

She could not forget having told him, "'Go to sleep, your pain will leave' . . . I knew he didn't want to die . . . and I didn't want him to, but I couldn't stand his suffering and I was told he was going to die anyway." She had been unable to cry at his death, nor has she been able to unburden herself by tears or words since.

This patient is a tall, well-proportioned woman. Beneath a dignified, stoic reserve, there is long-suffering in her expression and she seemed on the verge of tears as she told that her life with her husband was very lonely—full only of tragic memories of her son. While she exerted every effort to "keep herself together," it was apparent that she was threatened with going completely to pieces. Her voice and facial expression could not conceal sadness and hopelessness as she recounted the story of her life, dwelling on the son's illness and death.

Diagnostic Formulations. This patient's depression was severe and protracted. Her symptoms served the dynamic "need to be ill" as a critical defense against disintegration of her personality. She could not permit herself to express relief through any treatment. On the contrary, therapeutic measures for help or removal of symptoms only intensified her suffering. Her unconscious guilt was a crucial factor, but the secondary gain of her illness could not be underestimated. She seemed to balance the suffering with the advantages of her illness, by retaining and keeping at a distance her object relationships.

The clinical diagnosis was psychotic depressive reaction, while the psychological tests indicated "a woman of average intelligence with an obsessive-compulsive neurosis with depression. There is evidence of organic central nervous system involvement with premature aging."

Although there were four additional patients who attended the group sessions from time to time, all adult women, it is significant that those with disturbances other than polysurgery dropped out of the group.

IATROGENIC INFLUENCE TOWARD POLYSURGERY OBSESSION

Mrs. C. dramatically illustrates how a patient can be magnetically drawn to the iatrogenically-induced obsession for operation. Her series of five operations began at the age of 18½. She was admitted to the hospital for abdominal pain, of a sort not unlike that of which she regularly complained to the group. Although

a diagnosis of acute appendicitis was made, her pain characteristically cleared up in the reassuring atmosphere of the surgical ward. However, the surgeon, known for his aggressive practices, warned the mother, just as the patient was being prepared for discharge, that "it may happen again." The mother consented to laparotomy and a normal appendix was found. But the patient reported that an inflamed gall bladder was removed. She says, "As soon as a surgeon tells me there is trouble, I can't stand waiting. I want them to operate on me at once. They always promise cure." At another time, she said, "I haven't had a good day since."

Regarding polysurgery in gall bladder disease, it has been stated: "A willing patient and a surgeon ever ready to wield the knife is a very unfortunate combination... victims of a career of polysurgery... the end result of appendectomy is often polysurgery and chronic invalidism and its evil consequences."³

Mrs. C. was ever ready to sacrifice her time, asking whether she should skip sessions for another patient's needs. She admitted, "I don't stand up for my rights." She would offer to cancel her time if, as she suggested, the therapist had "more important business." (This patient's pace had been regarded as so slow in individual therapy, over a period of four years, that group psychotherapy had been recommended.)

MAGICAL AFFECT

Expression of the kind of magical exaltation and excitement experienced by these patients was voiced by Mrs. B. in the following: "I've had 10 operations. Every time I have an operation I then am on top of the world. I'm always either having an operation or recuperating. Something is wrong..."

She had had "50 nightmarish dreams." She says, "They are operating on me. I am in the organized chaos of the operating room, listening to them talk. I cry out." (Her three thoracoplasties were under local anesthesia so that she could hear and see.)

Mrs. E., whose attendance was the most irregular of the three patients, was a striking example of the "treatment-rejecting patient."⁴ She was the only member of the group to get herself a major operation while the sessions were in progress. Just a few months after they had begun she informed the group that one doctor had said her physical symptoms were "all mental" and "it

would be a crime to operate." "He told me psychiatry is the only solution, and gave me pills. A second doctor said I had diverticulitis, and to take a vacation. A third doctor, a *big* surgeon, said, 'You need an exploratory laparotomy.' But I don't want an operation. I don't know if it will help. I can't see it." She claimed her first operation, for a navel hernia, was performed in 1952, "even though I hadn't asked for attention for that, but for my arthritis. Since the operation, I'm a mess. And all my pains started then. They took my navel away. Emotions can make you sick, but my family don't understand. They say there's absolutely nothing wrong with me. 'It's all in your mind; people think you're a hypochondriac.'" Whereupon she belched in discomfort, and plaintively asked the therapist, "What would you do if you were in my place?"

A schizophrenic patient then attending the group replied in typical concrete language: "If he was in your place, he'd be sitting just where you are, coming here."

Mrs. E. reported to the group that she had an enlarged liver, although her recent medical work-up did not bear this out. She complained that the group sessions were not helping her. "It's all in my body. I need hormones. You don't give hormones, medicines or sleeping pills. I feel terrible. Don't you think we got to go to the medical clinic with these terrible pains? I've been staggering, after taking so much donnatal and thorazine."

Mrs. C. tried to reassure her: "Why don't you give it a chance?" Then, "I've told her she should be patient and tell her complaints."

PATIENTS INFLUENCING ONE ANOTHER

Mrs. B., the patient who had had 10 operations, said, "Don't you feel inside you need the operation? I would. I'd get another operation." Similarly, when Mrs. E. complained repeatedly that she felt like she was about to menstruate again, "all swollen up," Mrs. B. retorted, "Hysterectomy helped me. I'm not suggesting—but have a check-up." We see here how one patient in a group can influence another to get an operation. It is significant that it was after this particular session that Mrs. E. broke off from the group for a period of almost six months.

During Mrs. E.'s prolonged absence, Mrs. C. announced to the group that Mrs. E.'s husband had told her over the phone that

his wife had had a cholecystectomy. He had added, "She doesn't need any psychiatric care." When Mrs. C. telephoned another time, Mrs. E.'s husband advised her, also, to "stop the psychiatry and get surgery."

When Mrs. B. heard this, she said, "Everybody is a doctor. My husband, too, has told me not to bother coming here. My son accused me of not wanting to get well. He and the doctor harassed me into getting a thoracoplasty. My honest feeling was they needed training for chest service surgery. They needed cases." She also claimed her colitis began two and a half years before, after removal of a rectal polyp, her ninth operation.

Mrs. B. had recently insisted on a neighborhood doctor giving her a streptomycin injection for nosebleeds, even though she knew she had a history of severe vasomotor responses to antibiotics. She suffered marked collapse and shock, but only blames the doctor for his incompetence.

Mrs. B. and Mrs. C. reported that they had met Mrs. E. at the medical clinic in January 1956. She informed them her latest operation was a mistake, but that she would not return to the group sessions. However, they prevailed upon her to resume when she stated, "That surgeon disobeyed all the doctors here." She attributed her aggravation of symptoms to the operation. Here it can be clearly observed how easily one may fall into the trap of such patients, who maneuver others into the position of damaging them. This is an expression of their need to punish, blame and put others in the wrong. In this way of playing off one against the other—surgeon, physician, husband, group psychotherapist—she defied and attempted to defeat all. At the same time Mrs. E.'s "acting out" to get surgery dramatized vividly the reality of the polysurgery symptom. From then on the group's will to resist surgery, as well as accept the need and meaningfulness of the group psychotherapy, became more definite. Mrs. E., in reflecting the destructive trend of the operation addiction, not only became a scapegoat for the others, but showed them what they had to oppose in themselves. One might conceptualize that Mrs. E.'s behavior represented id strivings externalized, while Mrs. B. and Mrs. C. could now take on heightened ego and super-ego functioning toward the group. Mrs. B. and Mrs. C. drew closer together and seemed to be saying, "We, at least, will be good."

ASPECTS OF RESISTANCE

Certain aspects of the resistance of the "surgical addict" in group psychotherapy were expressed by Mrs. C., thus: "I can only have things nice and smooth. I guess I'm not made to carry troubles. I could never handle troubles without getting sick to my stomach. Maybe when I had my parents it didn't bother me. Now I have to do it alone." She said she wished there were a pill to make her feel like a human being. "But pills don't do any good," she said. "Once I would get a doctor to give them to me I didn't need them any more. I used to throw them out. And *surgery promises everything—complete cure.*"

When she attempted to stop dwelling on her somatic symptoms, her anxiety increased, accompanied by feelings that someone was following her—to murder, or rape her. She said, "People can talk about their stomachs, but you can't go around talking about sex. I'd rather have a bad stomach and a surgeon cut it out, than go insane with fears. I'll quickly take ulcers than a nervous breakdown. It's a terrible feeling when you get the fears. Pain isn't as bad as fears. If I'm too anxious I make the pain worse."

Mrs. E.'s response was, "I, too, would prefer anything to a nervous breakdown—except cancer."

DEPENDENCY

The group sessions were remarkable in their demonstration of the dependent, infantile character of the patients' object relations. Their life situations of invalidism were characterized by marked sterility of productive and creative functions. Mrs. B.'s son was the only living offspring of the three patients.

Each of the patients was grossly undeveloped sexually. Mrs. C. said she found sex completely distasteful, and would not discuss it except to say that she "accommodated" her husband. In individual therapy sessions, she had admitted that there was a pact between her husband and herself that as long as she was ill he would not expect her to have sexual relations with him, and he certainly did not expect her to bear a child. However, she did admit that there was some connection between her feelings about sex and her gastro-intestinal distress.

Mrs. E. described her wedding night as a "terrible ordeal. He hit the wrong spot. I was frightened, almost bled to death. I was

not even open." She was surprised that as a result of this experience she became pregnant.

On one occasion the hostility generated between Mrs. B. and her husband seemed to be a factor which produced an irritating rash on Mr. B.'s genitals and lower abdomen, so that they had to stop intercourse. She had constantly described severe family conflict and ambivalence toward her husband and also toward her son, a minister. "My son puts me in a rage," she said. "He tries to be my psychiatrist. He says, 'you're not sick, there's nothing wrong with you, you just want an excuse to lie down.' I can never stand up for my rights with my husband or with you. I stood up to you last week, but you're not close to me. Thank God, I don't want to be close to another man. I'll tell my son I *have* a psychiatrist. He's not my father. But I can't deal with people that count. It's because I love them that it hurts."

Then Mrs. E. asked, "Is there a feud in your family?" Mrs. B. replied, "There's no hate or love, just *sick* love."

Mrs. B. complained that her "disturbed thoughts"—about an injury going to happen to her son—and her hatred for her husband gave her continuous nausea, loss of appetite and weight. She said her husband likes her weak and in bed, unable to raise her voice, "since I don't obey him when I have strength." Although she boasted that it was "love" she put into the first night with her husband which caused her to conceive at once, she bemoaned that the pregnancy resulted in a relapse of her tuberculosis. She remarked, bitterly, "When you love someone, it hurts. *If I could only have a serious operation to take out love!*" In another session, she asked, querulously, "Do tranquilizers affect sex? I'm a vegetable!"

CRAVING FOR SYMBIOTIC RELATIONSHIP

The earliest phase of the therapy was marked by a modicum (in fact a minimum) of group interaction and participation. The patients attempted emotionally to eliminate the group and limit their attention to an almost exclusive symbiotic situation with the therapist. The "transference" might be viewed as pre-genital in nature, with intense dependence and the need for complaining and finding fault. These patients were not yet ready for a more mature co-operative group relationship. What they required more was a supportive therapeutic relationship.

Mrs. B. complained, "If I could only talk to the doctor alone, then I don't mind the group, provided he didn't reveal to the group. I don't want to discuss things in front of patients." She and her son made efforts to arrange for private psychotherapy with the writer, and discontinue the group.

In group sessions, Mrs. B. was easily angered if the therapist didn't take up her questions particularly. She accused the therapist of not answering her or explaining. She would cry, "I am *not* hostile—you frustrate me. Now I go to sleep, and you don't come to my mind any more."

Such repeated attacks were made with almost complete disregard for the group's existence.

When Mrs. E. missed sessions, Mrs. B. said, "Who cares! I'm better off without her. If just two of us, we'll divide the time into private sessions. How foolish if I get her in, when I can have private sessions with you. The heck with her if she has no sense. To make a long trip to get here and just to listen to somebody else?" She then said, "I know you, Mrs. C., one year, but certain things I couldn't tell—bosom things. Maybe to each other, but a third person would throw me off."

Mrs. C. also said she could not tell the group of her private family problems, and that it upset her if someone new came in with new problems.

When Mrs. E. did attend, she would monopolize and saturate the sessions with a flood of morbid memories of the sickness and death of her son. This aggravated her and gave her no relief. It tended to disrupt the cohesiveness of the group situation.³

The group vehemently opposed introduction of male patients, or even new female candidates.

INITIAL OPPOSITION

None of these polysurgery patients voluntarily sought psychotherapy. The request for it was imposed on them. They characteristically submitted. But there was concealed hostility to the referring physician for thus disposing of them. And there was resentment and doubt toward the group psychotherapist. Mrs. B. said, "I am nasty and angry and want to hurt you because I'm afraid I'm in your power, you could use the things you write down." She said she had a pact with her son to stick to psychiatric

treatment this time, after she had had a five-and-one-half hour talk with him.

On one occasion, Mrs. B. said that when doctors cannot diagnose, they use psychiatry as a "dumping ground."

Initially, these patients came to the sessions when they fitted into their convenience, in the course of attending medical clinics. As Mrs. C. would say, "To be honest with you, I came to the G.I. clinic this morning." Mrs. E. said, "What am I here for? I don't know what good I am getting out of coming."

They desperately clung to medical authority and to medications, tests and injections. When there was a conflict in schedule between an x-ray examination and psychological tests, the choice was not the latter. They also tried to change the therapist's mind about their need for psychotherapy. Thus, it appeared that the sessions were an "afterthought," or an opportunity for "killing two birds with one stone." Observations of these patients indicate that *to kill the pain of an offending organ means to them, killing that organ and getting rid of it, much like the way a dentist kills the nerve of an offending tooth and extracts it*. They try to kill feelings, too, as a defense against too strong feelings.

MASSIVE RESENTMENT

Beneath the patients' magical faith and trust in medical authority, and beneath their purported desire for help, they were pervaded by deep bitterness, distrust and gloom. In reaction to lifelong failure to attain health through symptom treatment—by drugs and surgical assault and irrevocable removal of questionably offending organs—they were discouraged; and they experienced a hopeless despair, a feeling of futility, and doubt that any therapy could really help or cure. For example, Mrs. E., before her third operation, told the group, "I got a terrible fear of a nervous breakdown. Our life is so empty. Maybe I try too hard to keep together." Mrs. B. said: "I had colitis and diarrhea—nine weeks. Everything came out. The hospital wasn't interested. What is group therapy? Five patients are too many. We don't get much. It surprises me that group therapy has had any success. This is so useless and a waste of time. You don't explain anything. Other doctors give."

When Mrs. E. was told that her repetitious complaint that she felt swollen up and like menstruating again might mean her de-

sire to have another child, she replied coldly, "That's psychological thinking. I don't think of my son. I don't believe in *any* doctors." This was the first time she had ever been so outspoken. The group situation had succeeded in revealing the massive resentment and hostility beneath her melancholy exterior.

RELAPSE OF SOMATIC DYSFUNCTION

After the sessions were suspended for the first summer vacation, each of the polysurgery patients had to make special visits to the gastro-intestinal clinic for relapses of their symptoms. As Mrs. B. greeted the group, "All of us had a bad summer." She had had a hemorrhoidectomy, her tenth operation. When the group psychotherapy was not available to meet their dependent needs, they were more susceptible to somatic dysfunction and surgery.

Many factors contributed to resistance-patterns of the utmost intensity. Formidable problems, perhaps more familiar in individual psychotherapy, are not less complex in the group process. Slavson⁶ has raised the question of the very existence of "group dynamics" in therapy groups. However, such problems derive from the particular nature and personality structure of the severe narcissistic disorders, including the psychosomatic, psychotic and addiction syndromes.

PROBLEM OF ANXIETY

The central role of the problem of anxiety and its ready transition to psychosis and/or operative surgery are suggested in the study of these patients. Mrs. E. frequently seemed on the verge of an impending psychotic breakdown. It appeared that her most recent operation was a defense against this threat. Mrs. B. had made one serious attempt on her life during a severe episode of depression. She reported, "Neither husband nor son have need of me. A semi-invalid's life is not worth living."

Mrs. C.'s intolerance for anxiety was stated most clearly, "I am ready for surgery—to cut out my brain." It is significant that in view of the intense mental agony she described, some psychiatrists were of the opinion that surgery of an offending organ—whether stomach or brain—might indeed be justified.

The writer disagreed, since mental and emotional states are often reversible, while parts of stomach and brain, once cut out cannot be replaced.

Mrs. C.'s anxiety was associated with her resistance to the verbal expression of hostility, a problem discussed by Spohnitz.⁷ This was considered a major stumbling block to the further progress of Mrs. C.'s psychotherapy.

The pessimistic attitude toward Mrs. B. was summed up by the psychiatrist who saw her when she was in the hospital and, in recommending psychotherapy, qualified, "Patient is hostile and schizoid. Treatment would not be helpful."

Freud himself considered the obstacle to the treatability of such narcissistic patients as almost insuperable. While his attitude is substantiated in the writer's findings, one can be somewhat more hopeful with such recent technical modifications of therapy as group psychotherapy. Although conflicts and complex resistances in this particular group remained to be more satisfactorily resolved and mastered, favorable results have been noted.

IMPROVEMENT

Emotional Improvement

There was general improvement in the three patients emotionally, with somewhat less confusion and ambivalence. There was a decrease of hopelessness and despair. Gradually, a more genuine, active desire to participate in the sessions grew. The patients' interest in each other and in each other's problems increased. Even though Mrs. E., after leaving, eventually returned to the sessions several times in response to messages from the hospital, progress toward getting her back seemed more marked when there was pressure from the other members of the group to *make* her attend, when the patients met at the medical clinic.

This group pressure was exerted particularly after Mrs. E. "acted out" and got herself a laparotomy, her third operation. Mrs. B. and Mrs. C. reported her "full of tremors and sheaves of prescriptions," reluctant to return. But they brought her back "into the fold," guilty, apologetic and symptomatically worse. She acknowledged that her surgery had been a mistake, and said that *her husband had talked her into it*. She said, "Now he is sorry, but *I* should have used my own head." However, she resumed her former preoccupation with her miseries. As she gave vent to her aggravated physical complaints, Mrs. B., the patient with the greatest number of operations, humorously and affectionately—almost hopefully—retorted, "She's going for four."

Later, after another hiatus of Mrs. E.'s attendance, Mrs. C. remarked to her, "I'll bake a cake if you'll come."

Improved Physical Functioning

Improved physical functioning was achieved with more regular attendance at the group sessions. Mrs. B.'s x-rays of the chest showed stability of the tuberculosis, and she had had no diarrhea or vomiting for 18 months. There was a moderate gain in weight and appetite. There were, likewise, attempts on the part of all three patients to reduce their dependence on drugs, as their anxieties were lessened through the growing influence of the group psychotherapy.

RESISTANCE TO SURGERY

While surgical treatment for the group therapy patients was not abolished, there having been two operations during the course of the sessions, there appeared to be strengthened resistance to it, as the patients emphasized more hope and desire for cure of their "surgery addictions." It is important to note, however, that when these polysurgery patients change, they may take on an anti-surgery attitude.

Mrs. E. said, "I don't know if I'm right or wrong here, but I don't want any more operations." Mrs. C. actually avoided—with comparative ease—a laminectomy for back pain. But she had suffered a severe bursitis of the shoulder for a year. Her orthopedist found such excessive calcium deposits in the x-rays that he considered the bursitis too far gone for conservative treatment and ordered her to be admitted for surgery within "the next two days."

The patient stoutly told him, "Can't I think it over?" saying she would rather wait a while. The pain subsided within a week. It was she who said, "When I get pain and go back to thinking it's something, or all organic, that the doctors can't see, even if you insisted, I wouldn't go to surgery. I'll take my chances and wait."

At another time, she stated, "If you talk of surgery for me, I don't like it. I used to think of surgery and fast cures, but I'm not like that now. I'll go to another surgeon or doctor, now, instead of operating right away." In fact, she told the group that she had been told to have a fatty tumor removed from her eyelid, but she had "obeyed" another doctor who said "no." She continued, "Isn't it progress that I do not go to a surgeon in spite

of all the ideas that a surgeon can relieve my mind, or *remove my mind by removing my brain*—or by holes in the head?"

Perhaps the maximum resistance to the surgical habit in these patients was voiced by Mrs. C., "If a surgeon—or even you—would tell me, I need an operation for holes in my head, I'd tell you to take it yourselves."

EVIDENCES OF MATURATION

Prior to group psychotherapy, it was thought that Mrs. C.'s massive anxiety and resistance to the verbal expression of hostility suggested that prevention of psychosis should be the limited treatment goal. Yet nearly two years later this patient could say, "I can talk up more freely now and answer better when I'm aggravated—unlike the way I used to be, when I would cry or get a stomach spasm. I don't know why I'd keep quiet even if I knew I was right, I'd get sick. It's part of my nature, like my mother. She couldn't speak up on what bothered her. I feel I am learning, but I've paid a price for keeping so quiet. *I'm growing up, but late.*"

Comparison of psychological records before and after group psychotherapy revealed remarkable progress in Mrs. C., with such significant findings as "a personality that has opened up, increase in productivity and spontaneity with intellectual and creative improvement."

Although this report is rather sensational, whether the gain will be held up remains to be seen.

FREEDOM OF EXPRESSION

Group participation and interaction was further demonstrated in the following: Mrs. B. was constantly finding fault with the group psychotherapy and the therapist. Once she said, "You've got rocks in your head." Mrs. C. replied, "You're *criticizing and insulting* the doctor. I'd never say he's got rocks in his head." Another time, when the therapist was late, Mrs. B.'s greeting was, "How's our beloved doctor? You remind me of a snail." Mrs. C., smiling more freely, said, "I used to shake when Mrs. B. would quarrel with you. I don't like when anyone gives *me* an argument. It will make me sick." Mrs. B. egged her on, "Let it out, Mrs. C., don't be so sweet. Take a whack at him. Getting mad has helped me get rid of vomiting and diarrhea." Mrs. C. replied,

"It's just that I can't. It makes me more sick. And *I've* got rid of *my* diarrhea without insulting." In another session, after Mrs. B. had engaged in one of her tirades against the therapist, Mrs. C. quietly said, "She's putting me to sleep. It's such nonsense."

In connection with recurrent gastro-intestinal symptoms, she reported that her physician had told her to get away from relatives who used her to talk of their sicknesses. She then showed she had become *more considerate of others*. "But I can't stop patients from talking of their sickness, or tell them I'm fed up. *They have as much right to be here as I.*"

FREEDOM TO DISTRUST DOCTORS AND TO CRITICIZE PARENTS

Mrs. B. had expressed her distrust of doctors. "Ever since the doctor on the ward showed my son my chart, where I had refused operation, that was when my son accused me of not wanting to get well." Mrs. C., who had once rigidly whitewashed her mother from any responsibility for her own difficulties, said, "There are resentments in us, even if we loved and obeyed. I look back now—did I ever do things so wrong? Why was she so fearful? I always felt under pressure if I came home late."

Then Mrs. B. could say, "I did have arguments with my mother. For example, she would say my dress was indecent and it wasn't." She went on to tell how her mother was similar to her husband, "a fiery type," and how her parents had "cooked up" her marriage. "I didn't even know I was being married—because my mother would not ask me, afraid I might say no. She thought she knew better. Anyway, I was in a gay mood and found myself married. Underneath, I was afraid I'd say no and run, because I was on the rebound from an affair with a gambler. I resented that I didn't get to know my husband longer, that I wasn't even proposed to and didn't know if I loved him."

At this time she was able to relate the critical setting and circumstances of what she described as her first pulmonary hemorrhage, which was during the depression year of 1932. She spoke of her husband's loss of his job, her mother's operation and subsequent death from cancer, the child in a coma from acute tonsillitis—and the worst feature of all, the husband's confession that he was "a failure and no good." She said, "I acted strange for myself. I walloped my child, then coughed up blood."

This relation was followed by more freedom to express intimate thoughts. For the first time, Mrs. B. *could report her dreams*. Then Mrs. C. disclosed dream material. Both patients' dreams were on a similar anxiety-producing thought, namely the death of a loved one.

Mrs. B.'s dream concerned, in an undisguised way, the death of her 81-year-old father, who had been seriously ill for a long time. Actually, her father did die, after an emergency operation, a few weeks later. It was significant that the patient attended the psychotherapy group immediately after having attended the funeral.

Encouraged by Mrs. B.'s relating of dream material, Mrs. C., with hesitant trepidation, discussed her own dreams. She dreamed that her younger sister—who, in reality, had a series of breakdowns—was dead. Mrs. C., actually childless, then came into possession of her sister's children.

INCREASED INTEREST AND UNDERSTANDING

Even the most overtly resistant patient, Mrs. E., who was beginning to show more positive responses, finally acknowledged that she *did not* understand her own behavior in getting operated upon and in her bad attendance record with the group. She welcomed some of the ideas advanced by the group members and the therapist, in attempting to explain her problems. She attended the sessions more regularly, saying that now she *wanted* to come; and if it was "emotional," she needed an outlet. She acknowledged that she was very lonely, had no one to talk to. She said her husband spent all his time looking at TV. She even came early to the session following this remark, saying that she had rushed to get there.

Mrs. B., sarcastically asked, "Do you think the doctor looks so handsome?" Mrs. E., with a broad smile, answered, "I *did* meet him outside." One of her most stubborn attitudes was expressed by her repeated assertion that she had to help *herself*, but she was able to add, "I wasn't brought up to take help. And I miss my mother's love as I get older." This insatiable longing could be related to her intense need to reject treatment in a group.

When Mrs. B. asked, "Why talk of the purpose of coming here?" Mrs. E. remarked, "There's no purpose in the way I live. The purpose is helping each other." Mrs. C. added, "The purpose is restoring health."

Mrs. E. then went on to point out how, through recent injuries, she "gets everybody to worry—and nobody ever worried about me as a child." Then when Mrs. B. said, "I come here to fight," Mrs. E. responded, "Maybe I need to fight, too,—we all realize we need you, especially when you don't show up." As to "doing it alone" she concluded, "No, I will come. I am not doing well by myself."

OBJECT RELATIONS OF ALL PATIENTS SHOW POSITIVE DEVELOPMENT

A friendship was developed between Mrs. B. and Mrs. C. by "telephone visits." But all the members of the group engaged in pre- and postmeeting get-togethers. Mrs. B. emphasized that her parakeet's second birthday coincided with the second anniversary of the formation of the group, and she referred to him in endearing terms, comparing her feeling to the former expression about "sick love" with her husband. She explained that her feeling of being needed was being fulfilled, and this kept her from being as helplessly agitated by her relationships with her husband and her son.

The inevitable breach, however, finally came between Mrs. B. and Mrs. C. This welcome occurrence was precipitated by an alleged misunderstanding about a schedule change. Mrs. B. asserted that Mrs. C. had failed to give her the usual friendly telephone communication and that consequently she had missed a group session. It was during that particular session that Mrs. C., alone, had had an opportunity to unburden her pent-up resentment against Mrs. B.'s "obnoxious" behavior. She referred to Mrs. B.'s arrogance and attempted domination of the sessions. However, she extracted a promise that this would not be discussed with Mrs. B. because, she felt, "Mrs. B. is too sick—she can't take it."

It was rather startling, then, when Mrs. C., at the next session, counterattacked Mrs. B. with some straightforward accusations. Mrs. B.'s reaction was one of incredulity—not only that Mrs. C. would criticize her, but that she had done anything which could be criticized. She expressed for the first time the belief that Mrs. C. had a closer relationship with the therapist than she had. And this was the first time that each of these patients had experienced genuine sincerity in her relationship to the other. It was remarkable to note that what no one had ever been able to do with Mrs. B. had been achieved by the mild Mrs. C. Although members of

Mrs. B.'s family, and also professional advisers, had constantly criticized her, it had only aggravated her. Here, at last, in this therapeutic setting, and coming from her fellow-sufferer, criticism had the desired strengthening effect of insight.

For Mrs. C., too, this was an important turning point in that she was able to criticize Mrs. B., a close associate, openly.

The patients had grown in understanding of themselves, and of each other, as the group therapist himself added to his understanding of the fundamental emotional and psychological mechanisms that played vital roles in the production of their surgical addictions. What was equally gratifying and effective was the patients' development of pressure for a psychotherapeutic attitude toward the group.

This was especially conspicuous and astonishing after the initial complete aversion, and lack of consideration, for the group therapy program. They even exerted pressure on absent patients, who had strayed back to surgery, to return to the group. They also wanted the therapist to make up any sessions they had missed and were willing to attend on days when they did not have to report to the medical clinic.

While several important problems remain unsolved (and despite the small number of patients described here), the findings are encouraging for extending such studies. It appears that a process of therapy can counteract and replace the trend toward polysurgery addiction as found in this group situation.

CONCLUSIONS

The following conclusions may be drawn:

1. The material discussed in this paper illustrates the value of the process of increased understanding and awareness by the group members and the therapist of the psychological and personality factors in the surgical-addiction problem.
2. Group psychotherapy is apparently a valuable method for developing a psychotherapeutic attitude toward the surgical addiction. The pressure on the ego for surgery can be replaced and counteracted by the pressure for a psychotherapeutic interest in the group.
3. There is value in showing the obstacles, disadvantages and negative aspects of group psychotherapy with the polysurgery patient, such as the individual patient's wish for symbiotic rela-

tionship with the therapist; the rejection of male, or additional new female, patients; the attempt to monopolize the sessions; the attempt to eliminate one of their own members; the suggestive influence of one patient on another toward surgery; the danger that the patient, in the process of change, may swing to an anti-surgery attitude.

4. There is also value in group psychotherapy of the polysurgery patient as shown by the following: improved object relationship, decreased desire to destroy themselves and the therapy; diminished anxiety; freedom for expression of hostile feelings and intimate thoughts; strengthened resistance to surgery and willingness to wait; improved physical function; consideration of others; interest in and understanding of each other's problems.

5. It is recommended that patients who are candidates for operation in surgical clinics be selected and screened for a trial of group psychotherapy for possible prevention of surgical addiction.

6 East 86th Street
New York 28, N. Y.

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EATING PATTERNS AND OBESITY*

BY ALBERT J. STUNKARD, M.D.

INTRODUCTION

The eating patterns of obese persons have long attracted attention and their potential significance in the pathogenesis of obesity has been recognized. They have not, however, to the writer's knowledge, been subjected to systematic study. The present report makes such an attempt. It briefly reviews investigation which has revealed that different kinds of obesity in the mouse are characterized by distinctive types of feeding patterns. This is followed by a consideration of the variables relevant to analysis of eating behavior in man. These variables are then utilized to delineate three deviant eating patterns which have been observed in obese human subjects. These patterns are illustrated by short case reports, and their significance for an understanding of obesity is discussed.

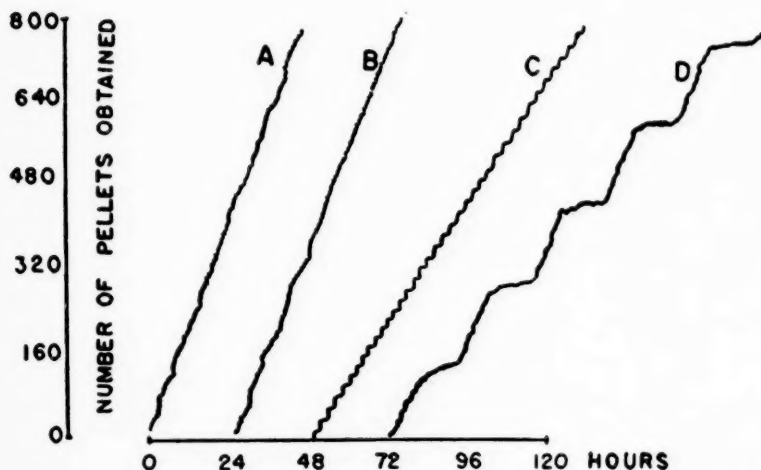
FEEDING PATTERNS OF OBESE MICE

A major advance in the understanding of problems of energy balance has been the discovery of methods for the production of obesity in laboratory animals. Within the last 15 years, three distinct techniques have been developed for this purpose: (1) the destruction of the ventromedial nuclei of the hypothalamus by the use of stereotaxic apparatus, (2) the administration of massive doses of gold thioglucose, and (3) the breeding of an obese-hyperglycemic strain of mice.¹ The types of obesity produced by these methods have been intensively studied, and a technique that has been as useful as any in characterizing the various types is analysis of behavior. This is most clearly demonstrated by the use of the Skinner box.² Animals confined in this apparatus obtain their food by pressing a bar which causes tiny pellets of food to be introduced into the cage. By registering each press of the bar on a continuous tracing, a graphic record of the frequency of feeding responses is obtained. Use of the Skinner box has demonstrated striking differences between the feeding patterns of non-obese and obese mice, and even between the feeding patterns of mice afflicted

*From the Departments of Psychiatry and Medicine, University of Pennsylvania, Philadelphia 4, Pa. This work was supported in part by the Research and Development Division, Office of the Surgeon General, Department of the Army, under Contract No. DA-49-007-MD-925.

with different forms of obesity.³ The figure, adapted from Anliker and Mayer, summarizes the results of this study, which delineated three different feeding patterns. Inspection of the curves provides graphic illustration of their characteristics.

FEEDING PATTERNS OF MICE



The figure is after Anliker and Mayer (Ref. 3). On the ordinate, is recorded the number of pellets of food obtained by the mice in units of time which are designated along the abscissa. Pattern A is that of a hypothalamic-obese mouse, Pattern B that of a gold-thioglucoase obese mouse, Pattern C that of an obese-hyperglycemic mouse, and Pattern D that of a normal mouse.

In the first place, the slope of patterns A and B is distinctly steeper than that of patterns C and D. This reflects the fact that the food intake of both the hypothalamic-obese and the gold-thioglucoase-obese mice is significantly greater than that of either the hereditary obese-hyperglycemic mouse or the normal mouse. Indeed, it will be noted that the slope of Pattern C is only slightly steeper than that of Pattern D. This characteristic illustrates the finding that the positive energy balance of the hereditary obese-hyperglycemic mouse is largely due to a decrease in energy expenditure, and its food intake is only slightly greater than that of the normal mouse.

A second characteristic of the curves is the absence of diurnal rhythms in the eating patterns of all the obese mice. The 24-hour cycle which is so prominent in the D pattern of the normal mouse is replaced in patterns A and B by the straight line, which indicates an almost constant rate of eating. The significance of the curious coarse grain of Pattern C has yet to be determined.

A third characteristic of the curves indicates that the study of feeding behavior may have predictive as well as descriptive value. At the time that this study was performed, the mechanism of gold thioglucose obesity was still unknown. However, the similarity of patterns A and B, which is indicative of similar feeding behavior of gold-thioglucose and hypothalamic obese mice, suggested that these two forms of obesity were closely related. A short time ago, this hypothesis was validated when it was shown that gold thioglucose produced chemical destruction of the same hypothalamic centers which were mechanically damaged in the hypothalamic-obese mouse.⁴

EATING PATTERNS OF OBESE PERSONS

General Considerations

The eating patterns of obese human subjects can hardly be described with a precision comparable to that which was possible in the case of the obese mice. This is particularly true of such formal characteristics of the patterns as the frequency and amplitude of the eating responses. Nevertheless, the student of human obesity has access to information about feeding behavior which is not available to the animal experimentalist, information which may be of value in understanding the far more variable course of obesity in man. Foremost among these sources of information are the obese person's reports of his experience. These reports have identified three variables which have proved useful in the definition of eating patterns in man. The first of these variables is the presence (or absence) of expressions of self-condemnation in association with a deviant eating pattern. The second variable is the degree of personal meaning or symbolic representation, which may be attached to the eating pattern. Finally, the subject's reports permit an assessment of the degree of stress to which he is being subjected at the time of his unusual eating behavior. It seems likely that these three variables do not exhaust the possibilities of

defining useful parameters for the characterization of eating patterns.

Use of the criteria which have been described has permitted the identification of three distinct patterns of overeating which are summarized in the accompanying table. Such patterns occur much more frequently in persons who are, or have been, obese. They may, however, occur in no more than a minority of obese persons, and even these may eat only a small part of their food in this manner. But when a pattern does enter into the eating behavior of an obese person, it does so with some consistency and may well make a significant contribution to the production and maintenance

Eating Patterns of Obese Human Subjects*

	Periodicity	Brain Damage	Relation to Stress	Apparent Personal Meaning	Associated Self-Condensation
Night Eating	x	0	x	0	0
Binge Eating	0	0	x	x	x
Eating without satiation ..	0	probably	0	0	0

*A representation in tabular form of the characteristics of the three eating patterns which are described more fully in the text.

of his obesity. Brief descriptions of the three patterns follow, together with short illustrative case reports.

Pattern 1

The first pattern, which has been called the "night-eating syndrome," is characterized by morning anorexia, evening hyperphagia, and insomnia.⁵ It occurs during periods of life stress and is often alleviated with reduction in the stress. Investigation has thus far failed to establish any consistent personal meaning of either the morning anorexia or the evening hyperphagia, in the sense that they constitute a symbolic representation or resolution of a conflict. Furthermore, persons manifesting this syndrome generally express little self-condemnation that is related to their overeating.

Case 1

H. G. is a 47-year-old woman who has been observed for five years, during which her weight has fluctuated wildly, from a low of 250 pounds

to an incredible 400, at which time she was unable to care for herself in any way, and, indeed, could hardly move. The onset of her obesity occurred at the age of 30, during a period of great stress following the death of her mother. At that time and, predictably, during periods of life stress thereafter, her food intake followed a night-eating pattern, always associated with considerable gain in weight. She would awake in the morning with no feeling of hunger and no desire to eat. Even when food was urged upon her, and even during periods when she was gaining 10 pounds a month, she would refuse to eat in the morning. She rarely ate before noon, and her food intake even at lunch and during the afternoon was very limited.

She usually began to feel a desire for food in the early evening, and would eat a large supper. Only temporarily sated, she soon returned to the kitchen and consumed larger and larger amounts of food at progressively shorter intervals. During these hours, she was assailed by loneliness and anxiety. To lessen her distress, she kept someone with her as much as possible, and, when she was alone, opened the door and windows, left all the lights burning, and played the radio loudly.

She rarely fell asleep before midnight, and usually awoke within an hour, anxious and hungry. Then she would eat a pint of ice cream and drink a bottle of soda pop. Temporarily satisfied, she would fall asleep for another hour before the cycle was repeated. Often she awoke three or four times a night to eat in such a manner.

The patient was observed several times at night during periods when she was manifesting the night-eating syndrome, and she appeared to be in the throes of an agitated depression. She would pace for hours, tearful and overwrought, intermittently trying to distract herself by reading and knitting, and eating anything she could procure by fair means or foul. In distinction to the diurnal rhythm of the depressive pattern, the storm would have passed by morning and the patient would have resumed the semblance of a jolly fat woman, a role she essayed in her more fortunate moments.

In further contrast—both to the depressive reaction and to the eating pattern which will be described next, there was a notable absence of any overt expression of self-condemnation. This particular woman had, in fact, developed to a very considerable degree the art of transferring blame to the environment, and although she was never frankly paranoid, she was able to keep her associates in a worried defensive posture most of the time.

Pattern 2

Some obese persons who have more than passing acquaintance with the phenomenon have aptly named the second eating pattern the "eating binge." As suggested by this title, such eating often

has an orgiastic quality, and enormous amounts of food may be consumed in relatively short periods. As is the case with the night-eating pattern, binge-eating, too, appears to occur during periods of life stress. In this latter pattern, however, dissociative processes seem to play a more important role. As a result, the relation of the eating binge to a specific precipitating event is likely to be both clearer to an observer and more obscure to the subject than is the case with the night-eating syndrome. Indeed, eating binges frequently seem to have highly personalized, if unconscious, symbolic meanings, and, again in contrast to the night-eating syndrome, they are regularly followed by severe discomfort and expressions of self-condemnation. As might be expected, binge-eating occurs with no particular periodicity.

Case 2

A. A. is a 30-year-old insurance salesman who frequently eats and drinks to excess. Since he periodically goes on brief but rigid diets, he has never become massively obese, but he has remained somewhat overweight most of the time. Every now and then, he overeats in a peculiar and most characteristic manner.

A. A.'s eating binges occur most commonly following some difficulty with his wife which might reasonably be expected to anger him. Instead, he is somehow able to convince himself of her unusual good sense, and go blithely about his business. Then, suddenly, out of the blue, he finds himself doing things which he considers utterly reprehensible. For instance, he might be walking down the street one day and then suddenly find himself in a grocery store, having bought an enormous quantity of food, all without any clear idea of how he had gotten there. At such times, he has a terrifying, uncanny feeling, but once having started on an eating binge, he is powerless to desist. As he explains it, "I don't know what happens. All of my good intentions just seem to fade away, they just don't seem to mean anything any more. I just say 'What the hell!' and start eating. And what I do then is an absolute sin."

After consuming all his grocery purchases in the shortest possible time, he sets out on a furtive round of the local restaurants, staying only a short time in each and eating only a small amount, constantly in dread of discovery. He is not at all sure what "sin" he feels he is committing; he knows only that it is not a pleasurable one. "I don't enjoy it at all. It just happens. It's like part of me blacks out, just isn't there any more. And when that happens there's nothing there except the food and me—all alone."

Following these binges, A. A. experiences awesome distress, and expresses the most bitter self-condemnation, always focused upon his eating, and rarely related to the interpersonal concerns which seem so clearly to precipitate the episodes. At such times he usually embarks upon a reducing regimen of a stringent, impractical character, and usually of very short duration.

The amount of food which A. A. consumes during a major binge may be of the order of 20,000 calories a day, since he has often gained as much as six pounds during one 24-hour period. Although such binges occur rather infrequently, lesser bouts of overeating, which follow the same pattern, seem to play a significant role in his continuing obesity.

Pattern 3

The writer has recently studied an obese man who manifests an eating pattern which might be called "eating-without-satiation." The most striking characteristic of this pattern is that the subject experiences difficulty in stopping eating once he has started, without, however, having shown any prior increase, either in the intensity of feelings of hunger or in the desire to eat. There appears to be no relation of this type of eating to periods of stress, and it manifests no periodicity, occurring in a random manner throughout the day. As in the night-eating syndrome, and in contrast to binge-eating, no apparent personal meaning can be ascribed to this pattern of food intake, and it is associated with no expressions of self-condemnation.

Case 3

Z. W. is a 20-year-old unemployed man who has suffered from massive obesity for the past eight years. His early growth and development had been normal, and he had always been in good health until the age of 12. At that time he suffered a very severe attack of encephalitis which culminated in three days of coma, after evidence of brain involvement. Z. W. recovered from this illness with no manifestations of brain damage that could be detected by either electro-encephalographic or neurological examination. However, psychological testing revealed moderately severe organic brain impairment.

When Z. W. returned home from the hospital his family noticed an unusual eating pattern which has continued to the present time. Whenever permitted free access to food, Z. W. will eat, and he will rarely stop eating as long as any food is available. This occurs from the time he awakes in the morning until he goes to bed at night. There is no evidence of any increased drive to eat; indeed he will not make any particular exer-

tion to obtain food. Furthermore, he is capable of restraining himself, at least over short periods, if he feels that the reasons for so doing are sufficiently compelling. For example, during a program of experimental studies which claimed his interest, he was quite willing to forego any food intake until after noon.

His eating is not associated with any evidence of guilt, and even when he discusses the obvious ill effects of his obesity, he expresses none of the self-condemnation so common among the binge eaters. Except for the inability to control his overeating, Z. W. appears to be relatively well-adjusted to a most difficult life situation. For example, during the first eight weeks after discharge from the hospital following his encephalitis, when food was freely available, Z. W. gained weight at a rate of 10 pounds a week. Although attempts were made then and many times thereafter to control his food intake, he reached a weight of 450 pounds by the time of the hospital admission during which he was studied.

Incidence of Patterns

The major sources of information about the incidence of these eating patterns is the relatively small number of obese persons treated by the author in the six years preceding this writing. Most of them had been referred to a special study clinic as a result of the severity of their obesity, or of difficulty in its management. The selection is therefore a biased one, and permits only cautious interpretation.

The first 25 obese persons treated in the special study clinic revealed an incidence of 64 per cent showing the night-eating syndrome, and the incidence in the next 15 patients was 66 per cent. In a questionnaire study carried out on 100 consecutive, and thus relatively unselected, obese persons in the nutrition clinic of the same hospital, the incidence of the night-eating syndrome was only 12 per cent. It is not clear whether this discrepancy results from different selection of subjects, different methods of collecting information, or both. It is worthy of note that the night-eating syndrome was not reported by any of a group of 38 control subjects with no history of weight disorder.

Since binge-eating has only recently been delineated as a distinct clinical entity, it is difficult to estimate its incidence. However, it is such a dramatic form of behavior that it seems unlikely that it would escape detection during even brief psychotherapy. It is, therefore, worthy of note that there is record of binge-eating in only three of 40 obese persons in the special study clinic.

Two non-obese persons, in whom there is a history of binge-eating, have been observed. Both of these were women, both schizophrenic, and both had been mildly obese at the time of their eating binges. When they were studied, however, both were underweight, and one was suffering from anorexia nervosa. This finding raises the question of whether the small percentage of obese persons who eventually develop anorexia nervosa may perhaps be confined to those who manifest the binge-eating pattern.

The pattern of eating-without-satiation was not present in any of the 40 obese persons treated in the special study clinic. However, it had been observed previously in a schizophrenic man following frontal lobotomy, during a period when he was rapidly gaining weight. Furthermore it was reported to be relatively common in a group of persons with extensive brain damage who were also obese.⁶ These observations suggest that the pattern of eating-without-satiation may result from damage to the central nervous system. The site of such damage is still not clear.

COMMENT

One of the most fruitful developments in our understanding of obesity has been the introduction of the psychosomatic point of view.⁷ Study of the lives as well as the metabolism of obese persons has yielded a vast amount of new information and has made it apparent that there are recurring themes in their lives. This finding has led to attempts to formulate a theory of obesity which ascribes primary etiological importance to psychological factors. The significant psychological factor has variously been considered to be: (1) a basic personality structure, (2) an increase in the intensity of certain drives, and (3) a basic psychodynamic conflict.

Despite the rather general acceptance of such hypotheses, none has been validated. Indeed, it has not even been possible to define psychological characteristics of obese persons which will consistently distinguish them from non-obese persons. In view of the apparent usefulness of the psychosomatic approach, it seems worth inquiring into the reasons for the failure.

A problem in much investigation of the stress disorders has been the need to explain too much too soon, and to generalize too broadly from valid but limited findings. Such issues may lie at the root of the failure of the psychogenetic hypotheses in obesity. For, in the ambition to explain all instances of obesity, it

has frequently been assumed, albeit implicitly, that obesity is a single disease with a single etiology. In the sense that the production of obesity requires at least a temporary disorder in the regulation of energy balance, obese persons do have something in common. But any physiological regulation is apt to require a complex piece of apparatus, and one as precise and vital as that controlling energy balance must contain a good many parts which could go awry. There seems to be no reason to assign all the possible disorders of all the possible parts to a single etiological agent. Indeed, the animal experiments described earlier provide excellent grounds for rejecting such a unitary hypothesis, even when dealing with obesity in animals. Such considerations must apply even more strongly in man, where the increased complexity of symbolic processes provides even greater possibilities for disorder.

Such considerations have persuaded investigators in several fields of research to consider obesity to be a symptom of multiple etiology. This viewpoint would appear particularly useful in psychiatric research. For if one did not feel obliged to find common features in every case of obesity, but could restrict one's efforts to members of subgroups of obese persons, it should increase the likelihood of discovering common and distinctive psychological features. Indeed, significant progress has already been made in this direction. By carefully delimiting the sample under study, Bruch, in her classic report on the family frame of obese children, was able to discover distinguishing psychological characteristics of an obese population.⁸ Subsequent investigations, which have been similarly restricted to subgroups of obese persons, have met with similar success.⁹⁻¹¹

These investigations have utilized such relatively nonspecific criteria as age, sex, and occupation in selecting their samples. However, if there are indeed different types of obesity, it would be preferable to select samples by criteria which might be more closely related to differences in etiology. Characteristic eating patterns may provide such criteria and may help to distinguish different types of obesity. For, as has been seen in the example of the obese mice, differences in etiology may be writ large in the behavior of the organism. An investigation of obese persons which seeks to find heretofore unrecognized differences as well as to con-

firm purported similarities may well be the next step in understanding obesity.

SUMMARY

This report deals with certain theoretical and clinical aspects of the problem of overeating and obesity. It considers the advantages, especially in psychiatric research, if obesity were found to represent, not one disease, but the end stage of a variety of different conditions with differing etiologies. Experimentally-induced obesity in animals serves as a model of such a contingency since it can be produced by different methods, which result in different types of obesity. Some of the most striking differences have been found in the field of behavior, a recent study having demonstrated characteristic differences between the feeding patterns of obese and non-obese mice, and even between the feeding patterns of mice afflicted with different forms of obesity.

The eating behavior of obese human subjects is considered from this point of view, and three distinctive eating patterns are described. The first of these patterns is that of the night-eating syndrome, characterized by morning anorexia, evening hyperphagia, and insomnia. The second pattern is that of the eating binge, in which large amounts of food are consumed in an orgiastic manner at irregular intervals. The third pattern is that of eating-without-satiation which has been observed in persons suffering from damage to the central nervous system.

Hospital of the University of Pennsylvania
34th and Spruce Streets
Philadelphia 4, Pa.

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A DIRECT ANALYTIC CONTRIBUTION TO THE UNDERSTANDING OF POSTPARTUM PSYCHOSIS

BY JACK ROSBERG, M.A., AND BERTRAM P. KARON, Ph.D.

Approximately 9 per cent of all psychotic reactions in women develop in connection with pregnancy, according to Pasquarelli's review of the literature.¹ Despite the physiological changes associated with pregnancy, he finds that "nearly all writers have agreed that psychological factors are of prime importance in the etiology of puerperal mental disorders." Unfortunately, there is no such agreement as to the nature of these psychological factors. As Pasquarelli points out in a footnote, "The discussion of psychoanalytic concepts... is unfortunately brief because of a lack of specifically pertinent literature."

Physical discomfort, the meaning attached to being a mother, and sexual guilt are mentioned in Boyd's description of the psychological roots of puerperal disorders.² The physical discomforts that he lists include pains and sleeplessness during pregnancy, exertion during the delivery, and exhaustion following it. According to Boyd, being a mother may mean the end of carefree youth, may mean being irrevocably tied to a husband who is disliked, and/or may mean having to compete for the husband's love (sibling rivalry). In discussing sexual guilt, he states that when such feelings are strong (especially when incestuous fantasies are involved), pregnancy may be seen as the punishment for sexual activities. Frigidity as an indicator of susceptibility to psychosis is mentioned by Boyd; Pasquarelli, on the other hand, doubts its prognostic value in view of its high incidence in the general population.

Pasquarelli mentions, as etiological factors, the anxious expectation of delivery as a great physical ordeal, leading to mutilation or death, and the factor of economic insecurity as indicated by the increased incidence of pregnancy disorders during the depression of the 1930's.

Both Boyd and Pasquarelli state in general terms that psychotic reactions are determined by the previous personalities of the patients and that one must be careful to distinguish cases where a previous psychosis is merely complicated by the pregnancy from those in which the pregnancy is a major etiological factor.

These discussions seem somewhat unsatisfactory. In the first place, most of the problems which are mentioned are such as to reach their maximum intensity before—not after—the childbirth; yet only 15 per cent of the psychotic reactions to pregnancy occur before delivery. Thus the great majority of pregnancy psychoses remain inadequately explained.

Moreover, the factors mentioned are more likely to lead to gradually increasing anxiety and guilt reactions than to an acute psychotic break. Davidson³ reported that patients in whom psychoses developed during pregnancy did indeed show gradually increasing mood swings, insomnia, headache, and mild anxiety. But he found a considerably different picture in postpartum cases: sudden onset, mostly with excitement, which was sometimes precipitated by the patient's return from the hospital. Again, one can find no adequate explanation in the literature.

Finally, the discussions of psychological factors by the writers surveyed seem superficial. Although fantasies are mentioned (incest, sibling rivalry), they are not thoroughly explored.

Fortunately, direct analysis, Rosen's method of psychoanalytic treatment of psychosis,⁴ provides an ideal technique for the investigation of underlying fantasies, because of the intensity and depth of therapy necessary with psychotics. In the course of the direct analysis of a schizophrenic woman, a postpartum case, certain fantasies were discovered which, the writers believe, shed new light on the postpartum psychoses.

The patient, a woman in her thirties, had been unsuccessfully treated in several institutions. Her treatments included both insulin and electric shock therapies.

At the time the direct analysis began, she was extremely aggressive, so much so that she was kept in restraint in bed during the first part of the therapy. Far from objecting, she preferred this treatment "because getting up makes me dizzy" (i.e., makes her lose control). At that time the patient was grossly overweight (approximately 55 pounds more than her normal figure). Most of this weight had been gained in the latter part of her institutionalization before the beginning of the direct analysis.

The reason for her illness, she said, was that "my husband made me pregnant." Pregnancy, she referred to, as "going through the mill." "The mill is responsible for my illness." At other times, she would deny any relationship between intercourse, pregnancy, and

children; she would then say that children came by an arrangement "with the state." During the "pregnancy" she was nauseated but never vomited, according to her account.

As the analysis progressed, it became clear that her husband had, in many ways, replaced her mother in her emotional life. Their relationship to her might best be described as dominating dependence, whereby the mother, and later the husband, dominated her so that she would gratify their own dependency needs. Her mother had forced the patient to assume the mothering role to the patient's own siblings, and finally to the mother herself, on innumerable occasions. The transfer of this attitude to the husband is exemplified by the patient's description of the role of the ideal wife: "A good wife calls her husband at his place of business at least six times a day to make sure that things are going well and that she's available in case anything comes up. Also, she tells him what to eat, and how much to eat, and also when to change his underwear and his outside apparel. If she doesn't do this, she can't be considered a good wife."

This replacement of the mother by the husband was most graphically demonstrated when the patient was finally able to face the fact that her feelings of guilt about sex were derived from her mother. She then identified the voice she heard saying "Shame, shame," whenever she masturbated, as that of her mother. At this point her mother's voice disappeared, only to be replaced by her husband's voice saying, "Hermit."

"Hermit" was a word of reproach used by her husband to her during their courtship when she seemed uninterested in getting married. She said that she did not know what he meant by it, and asked people for many years thereafter what the word meant, since her husband would not tell her.

The change in the hallucinatory reproach not only mirrored the earlier temporal replacement of mother by husband, but also reflected a change from guilt about sex per se as opposed to sex in which she did not gratify the demands of the husband (mother).

The reverse process, replacing the husband with the mother, was shown during the periods when she attributed pregnancy and children to "the state." The state, it turned out, represented the impersonal controlling mother. This same impersonal controlling mother was represented in her delusions by the cathedral of Notre

Dame, with herself as the cathedral's hunchback whose only security lay within the structure's impersonal confines.

Sexual relations were described by her as "the woman sucks with the vagina or mouth" (fellatio). She sometimes referred to her vagina as a "vagina-mouth." "A woman has two mouths: an oral mouth and a vagina-mouth." She insisted that she had "on doctor's advice" had intercourse "Russian style," that is she had put the testicles as well as the penis in her vagina. No matter how much she got she could never get filled. She referred to the testicles as "the two T's" which also seemed to mean teats. Semen, she said, was like milk. After intercourse she was full of "semen and milk."

"Being through the mill," her expression for pregnancy, referred to the "mill" where flour was made; flour was white like semen and milk. Pregnancy, she said, was being "filled up with semen and blood and milk." The swelling had the significance of becoming "more and more full." "It's the only time I was completely full." In other words, a pregnancy represented the final solution to the oral problems of her life. These may be summarized as having to give (be a mother) instead of receiving (mothered) which is the need of every child. The husband (who replaced the mother) was at last giving, instead of taking, during intercourse. But he could never give enough. When, however, she had actually been pregnant, this signified, on the level of fantasy, that she was getting "fuller and fuller" of milk. The satisfaction she longed for was at hand; but just when she was satisfied, the child would be born, and she would be empty again. During the period in her psychosis in which she had gained the excess weight, she had eaten prodigiously and was so fat "that I couldn't move." She said she had been trying to fill the emptiness, but she had never been satisfied.

"When I went to school, I was hungry. My mother wouldn't feed me. So when my husband badgered me to marry him I accepted, thinking he would provide me with the things I needed, food and a home. When it turned out that he couldn't I became pathological. The mill, or pregnancy as you called it, also did this and I got lockjaw." When the therapist interpreted the lockjaw as punishment for wanting to suck the penis or paternal breast, the patient got very angry, and denied the interpretation, saying it was "a movie version." She added that the therapist was "as draining"

as her mother, husband, and sisters, who, she said, made constant demands upon her. If only she could avoid these relationships and rest, she could "fill up again."

A good deal of the delusional material dealt with scars. She felt that she had scars all over her body, including her face. Almost all of these were hallucinatory. One scar which did exist, and which she talked about considerably, was a scar in the vaginal region caused by childbirth. The hallucinatory scars on her face seemed related to a sense of shame. In addition, these scars, with the other hallucinatory scars, were proliferated representations of the vaginal scar, which she felt was very ugly. When she said that this scar was "growing," she was asked if she felt the vagina was growing. She said yes, and indicated that she felt the vagina itself was very ugly, like the scar.

The "ugliness of the vagina" was related to her feelings of guilt about her sex (about being female), which, upon analysis, seemed to be predicated upon two fantasies: First, her mother needed a man and it was wrong, therefore, to be a woman; second, it was wrong for her to want so badly to be fed by the mother-husband as to have a second mouth—the vagina-mouth.

Thus, when the oral catastrophe of childbirth had befallen her, the earlier explanations for her mother's mistreatment of her were reactivated to explain the fantasied loss (that is, the loss of all the "food" that had been filling her).

The attempt at a psychotic solution to this oral problem may be seen in her description of her "two mothers, the person on the outside who calls herself mother and the mother inside of me that is warm, loving, and affectionate." Was it any wonder, then, that she should cling so tenaciously to a psychosis which included the inside mother, when recognizing the external mother seemed the only alternative?

To recapitulate the fantasy connected with childbirth: Being pregnant signified being filled with milk—the final solution to all the patient's deep oral problems—and the childbirth represented a catastrophic loss of this gratification. The prevalence as a severe oral trauma, of such fantasies of childbirth seems likely, because of their potency in precipitating psychotic reactions; the preponderance of oral content has long been reported in the literature on psychosis.⁵ pp. 387-451

Moreover, Seidenberg and Harris⁶ have noted the relative absence of nausea and vomiting before delivery in women who later developed postpartum psychoses, as in the case discussed here. This may be understood when one considers vomiting as representing an undoing of the pregnancy in oral symbolic terms (*cf.*, Grace and Graham).⁷ The woman heading for a postpartum psychosis has no wish to undo the pregnancy, it is the delivery which is the trauma. The observation that the return from the hospital is often the precipitating factor becomes understandable, inasmuch as the hospital represents a temporary gratification of oral dependency needs. The problem becomes acute when the patient is deprived of even this gratification.

At this point several objections may be raised to the implication that such fantasies as are discussed here form the basic factor in postpartum disorders: (1) That this is, after all, a single case; (2) that the case is that of a severe schizophrenic, whereas postpartum psychoses more frequently show manic-depressive than schizophrenic symptoms; and (3) that such fantasies might be present in previously pathological individuals but certainly not in normal persons or even in neurotics.

As to the first objection, a single case thoroughly understood is of far more scientific value than any number of cases superficially presented. And the other objections are based on the assumption that the fantasy pattern suggested here is special and limited—where the fact is that evidence can be cited pointing to the existence of this fantasy both in normal and pathological individuals. Further, there is value in setting forth a hypothesis, even when the initial clues are few, for only when a hypothesis exists, as a guiding thread in the scientific literature, can further empirical data be assembled.

Such fantasies as those under discussion operate largely on an unconscious level. But the unconscious can be unearthed, and the existence or nonexistence of specific fantasies can be determined through the direct analysis of psychotics and the conventional psychoanalysis of neurotics.

Interestingly enough, analysts (for example, Silverberg⁸ and Klein⁹) have reported dreams and fantasy productions of neurotics which are highly suggestive in terms of the present postpartum hypothesis. They report material which indicates that intercourse was viewed as being fed at the breast. It is a short step from such

a view of intercourse to viewing pregnancy as being filled with milk.

Moreover, Michel-Hutmacher¹⁰ reported that in response to the question of what they believed was inside their bodies, children up to the age of seven said that the body was a bag filled with food. From seven to nine anatomical details began to appear, but, only around the age of 10, were correct answers given. Apparently then, the notion that anything which fills the body is food not only can be found in normals, but is present *in consciousness* up to the age of seven.

Finally, consideration of a case of postpartum *neurosis* reported in the literature will serve to eliminate the possibility that this fantasy is peculiar to schizophrenic reactions. The case was reported by Freud¹¹ in 1893, when he was just beginning his discoveries. He treated the patient by means of suggestive hypnosis which was, surprisingly enough, successful. The patient, a young and normal-appearing woman, happily married and mother of one child, found herself repeating, with her second baby, certain extraordinary difficulties she had had with her first one. These had to do with her inability to nurse. As long as she tried to nurse her newborn baby, she was unable to eat, vomited, became agitated when food was brought to her bedside, and was reduced to a state of extreme depression and exhaustion. Her family doctors brought in Freud, and he tried hypnosis. The very first night he gave ordinary reassurances and commands: "Do not be afraid. You will make an excellent nurse and the baby will thrive. Your stomach is perfectly quiet, your appetite is excellent, you are looking forward to your next meal, . . ." and so on. This worked temporarily, but at noon of the following day all the mother's symptoms had returned. That night Freud hypnotized her again and this time "acted with greater energy and confidence. I told the patient that five minutes after my departure she would break out against her family with some acrimony: what had happened to her dinner? *did they mean to let her starve? how could she feed the baby if she had nothing to eat herself?* and so on." (Italics the present writers'.)

Note that this second suggestion was markedly different in character from the first. The first hypnotic suggestion had consisted merely of directions to suppress symptomatology, and its effects were temporary. The second suggestion was closer to an in-

terpretation: The patient was directed to express oral needs rather than to suppress symptoms. Surprisingly enough, this peculiar character of the second suggestion, which, the writers believe, accounts for its effectiveness, is nowhere discussed by Freud.

From then on, the mother had no trouble. "Her husband thought it rather queer, however, that after my departure the evening before she had clamored violently for food and had remonstrated with her mother in a way quite unlike herself. But since then, he added, everything had gone all right."

The symptoms returned with a third child, but again were relieved by Freud. Unfortunately, he was not concerned explicitly with psychosexual development at that time and so has left no hint as to whether the same kind of interpretive suggestion was responsible for the second "cure."

Freud—in 1893—then confines his theoretical discussion to a consideration of the hysterics in general in terms of the operation of an "antithetic idea" which he says is inhibited, dissociated, and "often" unconscious, and which puts "itself into effect through the agency of the somatic innervations" despite the conscious intentions of the patient.

"I therefore consider that I am justified in describing my patient as an *hystérique d'occasion* since she was able, as a result of fortuitous cause, to produce a complex of symptoms so supremely characteristic of hysteria. It may be assumed that in this instance the fortuitous cause was the patient's excited state before the first confinement or her exhaustion after it. A first confinement is, after all, the greatest shock to which the female organism is subject, and as a result of it a woman will as a rule produce any neurotic symptoms that may be latent in her disposition."

From the vantage point of 1956, one may believe that Freud's 1893 discussion can be expanded to include the rather important description of the "antithetic idea" in terms of the later development of Freudian theory and of the present writers' own investigations. The remarkable effectiveness of the direct suggestion would seem to be due to its interpretive character. This interpretive suggestion consisted of directions to act out the oral problems which the writers have reconstructed in their own schizophrenic patient. When Freud's patient was able to comply, the symptoms disappeared.

SUMMARY

The deficiencies in our present knowledge of postpartum psychosis seem to be due to the inadequate consideration which has been given to the fantasy structures which underlie the traumatic impact of childbirth.

Through the direct analysis of a schizophrenic woman with a postpartum psychosis, certain fantasies came to light which shed new light on the problem. Pregnancy had the significance to her of the final gratification of unresolved oral fantasies. The patient felt the increase in girth as caused by the body's filling up with semen, which was equated with milk. The delivery was then viewed as a sudden catastrophic loss of this gratification.

Such unconscious fantasies seem to account for many of the unexplained characteristics of postpartum disorders.

439 S. La Cienega Boulevard
Los Angeles 48, Calif.
and
Princeton University
Princeton, N. J.

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ANTI-DEPRESSANT EFFECT OF CERTAIN PHENOTHIAZINE COMBINATIONS*

BY ANTHONY SAINZ, M.D.

Denber¹ suggested in 1957 that the combination of diethazine and chlorpromazine was responsible for states of hyperdynamia, and even out-and-out excitement—greatly resembling emotional outbursts—in depressed, torpid and obtunded patients. Denber was concerned at the time in investigating the electro-encephalographic changes produced by such compounds in depressed patients.

Because of work already undertaken by the present author and co-workers, on phenothiazine and other di-phenyl compounds,² Denber's observation led to a new research project. It had already been noted² that many patients, while being treated with phenothiazines, developed headaches when placed on concurrent ethopropazine for parkinsonoid reactions. This led to the investigation of the possible anti-depressant activity of diethazine and congeners, when combined with different available phenothiazines.

The research design for this project required a strict interpretation of psychiatric depressions. This term is usually employed very loosely, and among cases classified as "depressions," one often finds typical physiological retardations, psychic obtundities, autisms, acted-out crises of neurotic self-pity, schizophrenic pseudo-depressions, and many amorphous states in which "depression" is diagnosed or assumed only on the strength of the patient's assertion that he "feels that way." Failure to exclude these "depressions" would lead infallibly to the pitfall into which many unwary clinicians have stepped, with claims of "good to excellent results" in conditions that are mainly the pseudo-depressive syndromes described. These usually show excellent response to any therapeutic agent, at least for a period.

In some years of clinical studies of depression—particularly with ECT techniques, and later with drugs—the author became convinced that even in true depressions, a certain percentage tends to show spontaneous improvement. This conclusion was corroborated by observations made at Marcy (N.Y.) State Hospital in 1956, and is now reported here, since it is most germane to the

*From the Division of Research, Marcy State Hospital, Marcy, N. Y.

subsequent conclusions of this paper. Thirty depressed patients, admitted to Marcy between January and July of 1956, were observed by the author. They were selected in sequence from new admissions and were included for observation only when (1) they were adjudged true endogenous or neurotic depressions and, when (2) they were not placed on active treatment (ECT, phrenopraxic drugs in therapeutic doses, etc.) immediately upon admission.

Of these 30 patients, six improved markedly within three to six days after admission without any active treatment, while only on routine supportive procedures on the ward. Within two months, all six of these patients had ground privileges, and were going home on visits; and all six were dismissed from Marcy from four to six months following admission. The 24 remaining patients of the group showed, in general, very mild improvement which might better be called "accommodation" to the hospital routines, but all had to have active treatment of one kind or another before there was any further noticeable improvement.

A follow-up, however, showed that all six patients who showed the "good to excellent" improvement without active treatment eventually relapsed. One committed suicide two weeks after discharge; another attempted suicide, but was unsuccessful and returned to Marcy within a month. The other four felt well only for short periods following release, and returned in from three to five months to the hospital. As this demonstrates, these improvements were apparent rather than real, and the psychopathology behind the depressions continued unabated. Had these patients been treated by some inert medication or technique, they would have shown up in the results as "six remissions": a most misleading conclusion, and a most serious error, when one considers that they constituted 20 per cent of the group studied.

As precautions against these "spontaneous improvements" and false results, the present research design, therefore, included the following requirements:

1. Only two types of depressions were recognized as genuine in each diagnostic category:³ overt and "larval." The former must comprise a genuine sadness, based on some sense of loss; behavior concordant with this feeling of sadness; decreased mental productivity or constriction of thought as a defense against the feeling

of pain; preoccupation with self and decreased ability to handle dependency-hostility needs; and, finally, some measure of alteration or diminution of psychomotor activity. The "larval" state includes those depressive features—basically fulfilling the requirements for the diagnosis—but, in the "larval" state, the syndrome is masked by symptomatic equivalents of entirely different ostensible values. The real nucleus of the disorder is shrouded under a cover of different markings, from which it may eventually emerge a full-grown, foudroyant depression. For this reason the writer calls this condition "larval."

2. The test conditions for a satisfactory therapeutic agent were that it be capable of producing a measurable improvement within a week, even if not a complete remission; and that the patient be considered "75 per cent improved" in the next two weeks. These requirements are met by electric shock therapy and it is felt that satisfactory anti-depressant medications should not have less beneficial response, nor a slower one, than that shown by ECT.

3. To screen out spontaneous improvers, all anti-depressant medication was withheld from the patients to be tested during the first three weeks of hospitalization. They were allowed to have, if they showed anxiety or agitation, a sedative known from experience not to influence the course of the syndrome under study (such as chloral hydrate, phenobarbital, or subtherapeutic doses of chlorpromazine). To make doubly sure that "spontaneous improvers" would be weeded out, one or two placebos were administered during the screening period. All patients showing "remarkable" improvements during this time were dismissed from the study group. This research design is the standard procedure at Marcy in evaluating the effects of different agents on the depressions.

Thirty-eight patients were studied from May 1957 to May 1958. Twenty-three were women. Ages ranged from 32 to 74. Eight were out-patients and the remainder were hospitalized at Marcy State Hospital. Twelve cases were considered to be chronic neurotic depressions, six depressive-affective disorders, two were psychotic depressions of the elderly, 12 were depressions of the involutional period, and the rest were depressions associated with other

psychiatric syndromes, or "pfropf-depressions" (four schizophrenias and two mental deficiencies).

This last group, that of depressions associated with other psychiatric conditions, comprised six chronic patients who had not responded satisfactorily in the past to other treatments. Their lowered motivations and drives, however, could be, at least temporarily, improved by ECT; for this reason, they were used as controls.

These six patients made up the first group to be tested, and they received a combination of 100 mg. of chlorpromazine together with 250 mg. of diethazine, orally, q.i.d. Four patients showed noticeably increased drives in a week's time; and one of these four became over-stimulated and noisy in three weeks. The fifth and sixth patients showed vague changes that could not be properly graded, and the results were considered negative. Because diethazine is not readily obtained in this country, (the supplies were by courtesy of Denber¹) it was decided to try in its place, a readily available congener: "Parsidol" (ethopropazine). Its administration produced in the same six control patients, an identical effect to that of diethazine and chlorpromazine, at doses of 100 mg. each of ethopropazine and chlorpromazine. Medication was then discontinued; and once the stimulation subsided and the patients had returned to their previous level, the same-sized doses of chlorpromazine, diethazine, and ethopropazine were administered successively, but singly, not in combination. Chlorpromazine produced a certain amount of sedation, but none of these drugs, when administered alone, produced any noticeable stimulation. A combination of mepazine and ethopropazine also proved to be as effective with the control patients as the two previous combinations of diethazine and ethopropazine with chlorpromazine. (See the accompanying table.)

The remaining 32 patients comprised the study group. Four of these received 100 mg. of chlorpromazine + 1/100 grain of atropine, q.i.d., and four others received 100 mg. of chlorpromazine + 1/150 grain of hyoscine, q.i.d. No anti-depressant action was observed with these combinations, and they were ineffective also with the controls. The eight study group patients, and some others were later placed on chlorpromazine, 50 to 100 mg., q.i.d., plus ethopropazine, 100 mg., q.i.d.

Results Summarized of 92 Trials For Anti-Depressant Effect of Various Drugs and Drug Combinations Tested in 38 Mental Patients

Syndrome	Group A			Group B			Group C			Group D			Group E			Group F			Group G		
	Remission	Improved	Unimproved	Remission	Improved	Unimproved	Remission	Improved	Unimproved	Remission	Improved	Unimproved	Remission	Improved	Unimproved	Remission	Improved	Unimproved	Remission	Improved	Unimproved
Neurotic depressions ..	8	0	0	2	0	0	2	5	2	1	3	0	0	1	0	0	..	..	..	..	..
Affective depressions ..	6	..	..	..	..	..	..	..	..	..	2	1	2	0	1	0	0	0	2	0	0
Senile psychotic depressions	2	..	..	..	..	..	..	..	..	..	..	..	..	1	0	1	..	..	..	..	..
"Involutional" depressions	12	0	0	3	0	0	2	..	..	..	0	2	2	4	1	3	0	0	2	0	0
"Prolif-depressions" (controls)	6	0	0	6	0	0	6	0	4	2	0	4	2	0	4	2	0	0	6	0	0

The results of 50 trials are reported for the 32 patients in the experimental group. The six control patients are reported seven times each. The (..) indicate no trial by a member of the specified diagnostic group of the drug or combination indicated.

"Improved" as used here indicates "noticeable improvement"; "unimproved" indicates "very minor or no results."

Group A.: chlorpromazine administered alone.

Group B.: diethazine or ethopropazine administered alone.

Group C.: chlorpromazine + diethazine.

Group D.: chlorpromazine + ethopropazine.

Group E.: mepazine + ethopropazine.

Group F.: chlorpromazine + atropine (gr. 1/150 of atropine p.o.).

Group G.: chlorpromazine + hyoscine (gr. 1/200 of hyoscine p.o.).

Twelve patients were tried on mepazine-ethopropazine because, on chlorpromazine, some of the patients showed parkinsonoid rigidity and, generally, acathisia (in spite of ethopropazine being a most effective antiparkinsonian agent), dry mouth and blurred vision, or a noticeable hypnotic effect. At the doses employed (50 mg. of mepazine plus 100 mg. of ethopropazine) mepazine does not have the side effects found with chlorpromazine. The anti-depressant effect was on the order of that observed when chlorpromazine was used instead of mepazine; and other patients were shifted to the mepazine combination. A similar anti-depressant effect was noted on combining trifluopromazine with ethopropazine (not shown in the table).

The table summarizes the results of different drugs and combinations used in this study; all changes rated as improved ("noticeable improvement") appeared within a week of starting treatment. Remissions were considered cases which, after an initial noticeable improvement, went on to become symptom-free and remained that way for a minimum of six months. No patient in this group was followed further than that.

As can be seen from the table, nine of the 12 patients with neurotic depressions went into remission or showed improvement. Only one case was an outright failure. In the manic-depressive, depressed, group, more than half improved or went into remission, while one-third of the group failed to show improvement. In the psychotic depressions of advanced age, one of the two patients responded readily, and the other did not; the results are not illuminating. Seven of the 12 patients with "involutional" depressions improved substantially or went into remission, but five failed to respond. Of the five failures in this group, one subsequently responded to electric shock, and one to pyrrolazote. The other three remained unchanged.

SUMMARY AND CONCLUSIONS

A controlled study employing a rather rigid research design was conducted to determine if combinations of chlorpromazine or similar phenothiazines, with diethazine or congeners, possessed any cerebral-stimulating or anti-depressant properties. This study was conducted on 38 patients; and the results indicate that the combination of chlorpromazine or congeners with diethazine or congeners as reported here has a very definite anti-depressant effect

which is most marked in neurotic depressions. The amount of relief given by these combinations, and the lapse of time in which the improvement is manifested, compare favorably with electric shock therapy. It is concluded, however, that electric convulsive therapy is more effective and more generally applicable in manic-depressive, depressed patients and "involutional" depressions, than these phrenopraxic combinations.

Division of Research
Marcy State Hospital
Marcy, N. Y.

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NOTES ON THE USE OF RECORDED MINUTES IN GROUP THERAPY WITH CHRONIC PSYCHOTIC PATIENTS*

BY JOSEPH H. GOLNER, HAROLD M. GEDDES, AND JOHN ARSENIAN, Ph.D.

This article describes an expanded type of participation in group therapy by the person recording the minutes. A recorder or observer-recorder is often described as an integral part of the practice of group therapy. In a review of "group methods in psychotherapy," Frank briefly described the role of the observer and—a matter of particular interest here—remarked that there has been little direct use of the minutes or records made by the recorder. Frank's 1952 statement continues to reflect the general situation: "Observers are frequently used to help the therapist keep track of the events of a meeting, including especially the effects of his own behavior. . . . Observers may sit in the back of the room and confine themselves to recording the meeting or may participate as additional therapists. They are seldom used for 'feedback,' i.e. reporting their perceptions of what is occurring to the group during a meeting because this function is usually reserved to the therapist."¹

Concerning specifically the "use of recorded minutes of group meetings in group psychotherapy," Pinney, noted that through July 1952 "no report of the therapeutic utilization of similar material had appeared." So Dr. Pinney could subtitle his paper: "A preliminary report on a new technique."²

Pinney's project and the one discussed here are broadly similar in rationale and procedure: the "feedback" of minutes to the group. One conspicuous difference was the status of the recorder. Pinney's recorder was a group member, a patient who had been a professional secretary. She volunteered to record and her minutes were read at subsequent meetings, "at first by the therapist, but later by the secretary herself."

In the present situation, the recorder, like the therapist, was a psychiatric social worker. He had served as an observer and recorder for two months, sharing his observations and notes only with the leader and only after the meetings. With the change, came the sharing of his notes with the entire group. Seated out-

Observations based on experience at Boston State Hospital, Boston.

side the group circle, he confined his verbal participation to presenting a review of the previous meeting.

There was also a difference in timing, Pinney introducing the minutes *late* in the hour, in order not to "inhibit spontaneous discussion," but not so late as to cut off comment and reaction.³ In the present trial, the minutes were regularly introduced at the start of each meeting.

Despite these differences and others, such as differences in sex, number, and diagnostic composition of the group, the present writers share Pinney's evaluation of the procedure. "Generally the patients seemed fascinated at hearing the minutes read and were very interested in them. These emotional responses were very striking in otherwise unresponsive schizophrenics."⁴

In the rationale for introducing the minutes to patients, the hypotheses that *reality-testing*, *self-objectification* and *self-confrontation* would be therapeutically increased were common to both efforts. The former concept, borrowed from psychoanalysis, was used in both studies. The latter two were borrowed by the present writers from Allport's characterization of aspects of psychological maturity.⁵ A similar concept has been expressed by Ruesch and Bateson in their analysis of patient-psychiatrist communications: "In a circular system the observation of feedback operations enables the psychiatrist to assess the patient's ability or inability to correct messages received and sent, which correction necessitates the patient's observation of his impact upon others, and of others upon himself."⁶

The minutes pose a recurrent challenge to group members to confront reality and the self objectively. This thought was clearly stated by Pinney: "Hearing his behavior described and commented on by the group gives the patient a chance to see himself from an objective viewpoint and to see how he appears to others in the group. His psychotic behavior, predicated on the replacement of reality-testing by hallucinatory and delusional thinking, is shown to be inadequate. His attempts to regain lost reality are facilitated by this method of reading minutes. He can re-experience a reality situation as it occurs in the minutes, and can re-evaluate his part in it."⁷

Incorporated in this report is a more detailed account of each patient's reactions to the feedback procedures, and some notes by the therapist and the recorder on its effect upon them.

COMPOSITION OF GROUP

The group studied consisted of 11 patients whose ages ranged from 26 to 50 and averaged 42. Duration of hospitalization ranged from five to 17 years and averaged 10. The members' diagnoses were: five, dementia praecox, paranoid type; two, dementia praecox, other types; one, dementia praecox, simple; one, psychosis with mental deficiency; one, alcoholic psychosis with paranoid features; one, psychosis with psychopathic personality. Four patients had ground parole; the remaining seven were in locked wards.

PROCEDURE

To observe the effects of the feedback of minutes of the previous meeting upon the group, a period of five meetings before the reading was used as a base-level. This period was compared to the first five consecutive meetings after the reading. The comparison was made in ratings of variables for both individual and group behavior. Of necessity, the ratings are subjective, based upon concurrence of judgments of the leader and recorder, made with continuous reference to their shared experience and the records. "Individual variable" refers here to some aspect of a member's participation, while "group variable," of course, refers to aspects of the group-as-a-whole.

Definition of Variables

Individual Variables: (These were the basis for separately reviewing and tallying each member's style of participation.)

Verbal productions: any verbal activity.

Interaction with leader: comments directed to the leader or recorder.

Interaction with members: comments directed to other members or to the group as a whole.

Relevant participation: contributions pertinent to the group discussion or concerning an issue significant for the group.

Filibustering: verbal activity designed to interfere with group discussion.

Mumbling: utterances which cannot be clearly heard or understood, despite encouragements to "speak up."

Talking to one's self: talking considered to be autistic.

Nonverbal productions: activity which is not verbal such as sing-

ing, walking, laughing, moving chairs, etc., and is unusual for an individual.

Movement toward the group: observable physical and/or psychological interest directed toward the group.

Activity level: A crude summation of physical movements, other than sitting still, by an individual member.

Observable anxiety: behavior and feelings showing discomfort, presumably associated with what is going on in the group.

Quality of participation as influenced by innovation: any change in an individual's contributions judged to be a result of the feedback.

Over-all evaluation of feedback for individual: The positive, negative or undeterminable effect of the feedback.

Group Variables: (These variables relate to the functioning of the group-as-a-whole. By their nature they are more subjective and difficult to rate than the preceding ones.)

Cohesion: ability of the group to feel and work together.

Jamming: two or more members talking simultaneously about different things without paying attention to each other.

Focus on group issue: ability of the group to concentrate on a subject.

Continuity of group issue: ability of the group to concentrate its discussion on what went on in the preceding meeting.

Clique formation: two or more members preferring to talk among themselves rather than participate in the group discussion.

Affectional ties: expression of warm feelings toward each other, the leader, or recorder.

Anxiety: the general behavior and/or feelings of the group-as-a-whole that manifest discomfort—presumably activated by what is going on in the group.

Interest: attention of the group-as-a-whole to what is going on in the group.

Total member-to-member interactions: nonverbal and/or verbal communication between individual members.

Total member-to-leader interactions: nonverbal and/or verbal communication between individual members and the leader or recorder.

Rating Procedure

Changes in individuals and the group following the introduction of the feedback were evaluated by ratings on these vari-

ables. The ratings were the pooled subjective impressions of the leader and recorder, based on their experience in the meetings and on review of the accumulated records of the five meetings before the innovation of the feedback and the five meetings following it.

A five-point scale with a midpoint of "no change" to express a steady state, and categories allowing for *slight* and *moderate* increases or decreases, was applied to the groups of five sessions before and after the innovation.

INDIVIDUAL CHANGES FOLLOWING INNOVATION OF FEEDBACK

The following analysis will present for each of the 11 patients studied, a brief description of his typical behavior in the group. Details of changes based upon the ratings are omitted. Only the over-all effect of the feedback is noted, together with an expression of each member's attitude toward the feedback, often referred to as the "notes."

The results may be summarized in three classes: those favorably affected, five patients; those unchanged, four; and those unfavorably affected, two.

Patients Favorably Affected

Mr. Mur usually stands outside the group, mumbles, yells and frequently masturbates. He has the disfavor of other group members because of his masturbatory activities and noisy behavior. His verbalizations are rarely understandable.

The over-all impression is that *Mr. Mur* has benefited from the feedback. His attitude is positive, expressed by such comments as "I like to be in the headlines," "You can quote me on that," "You can write all you want to, I don't care," "The notes are very interesting and interestingly read," "I am satisfied."

Mr. Hen always speaks sarcastically of what the leader and group can offer him. He consistently complains about the leader's not helping him or the group, and attends group meetings only because of external pressure. His characteristic pattern is to walk out of the group circle in disgust, and then to return.

This patient seems to have benefited from the feedback, despite his own negative attitude toward it.

His objections were expressed by comments: "It's a cheap program," "Take down all the notes you want," "Notes are going to

the State House." He often interrupts the reading of the notes to correct or confirm references made to him: "I'm an important man," and, "It's a lie." In reply to the leader's question, he says sarcastically, "The notes are very interesting." He asks, "What do they all add up to, how do they help the group?" He states he does not want what he says in the record and sometimes speaks very quietly so that he cannot be heard by the recorder.

Mr. Cos can be described as raving and sarcastic on the one hand and friendly, co-operative and sympathetic to the leader, on the other. The group seems to be more important to him than to any other patient.

This patient definitely benefited from the innovation.

Despite ambivalent feelings, his is the most positive of the entire group. He says that though the others say the notes are feces, he likes them. Immediately after the reading of the notes, he approvingly exclaims, "Well!" or "Good!"

Mr. Min usually directs his comments to the ceiling, invokes the gods and "plebians" and sometimes concludes his remarks with "normal." He filibusters a great deal, and conceals his intense hostility by profuse apology.

He seemed to benefit from the innovation of the feedback, despite strong negative feeling. He said, "The notes are bad publicity, but have to be read," "Stop spreading poison," "I criticize the notes and cannot apologize." He says he would stop them if it were in his power, but say that "otherwise" he is helpless. He attempts unsuccessfully to get other members to agree with him that the notes might do damage and are an infringement of the patient's rights. He finally resigns himself ("Oh, hell, I give up") and pleadingly turns to Mr. Geddes, the recorder, saying, "You won't listen."

Mr. Cre's behavior is characterized by ambivalent co-operation. He attempts to talk only to the leader, lays claims to illiteracy and indulges in a great deal of "fog-talk" and filibustering.

Mr. Cre has definitely profited from the innovation. His attitude is very positive. He says that the notes are "the only logical sound in the meeting."

Patients Unaffected

Mr. Stu, probably in better contact than any other group member, is very quiet and participates little. Usually compliant, his comments have been limited to replies to the leader's questions.

It is undecided whether the feedback made any difference for him. His attitude seems to be a compliant acceptance. Asked what he thinks of the notes, he says it is "O.K. to have them read," "It is the group's worries, not Mr. Geddes'." He "doesn't know if the notes help, they show what goes on," adding, "It's a lot of talk, that's all."

Mr. Arr, quiet and catatonic-like, uses only one or two stereotyped phrases. Once in a great while, he jumps up, and gesticulates excitedly. Immediately afterward, he sits down again. He complies with the leader's invitation to join the group circle.

It could not be determined whether he profited from the reading of the minutes. His attitude is apparently negative, as indicated by the shaking of the head.

Mr. Ber attends group meetings reluctantly. During the meetings, however, he responds to the leader's invitation to join the group and helps out in moving chairs and other custodial tasks. He does not usually volunteer contributions and, like *Mr. Stu*, does not appear to be obviously psychotic.

It was undecided whether this patient changed with the innovation of the minutes. *Mr. Ber's* attitude is one of indifference. When asked if he thinks the notes are valuable, he says, "It's only two weeks, and it takes time." Asked if he objects to them, he says, "I guess not, since I didn't object when they were read."

Mr. McK has not said a word during the group's entire history.

It was undecided whether he benefited from the readings. His attitude cannot be determined. His nonverbal behavior showed a slight decrease.

Patients Unfavorably Affected

Mr. Con is a very passive patient. In the group, he alternated between being ingratiating and mimicking the leader. During meetings he tends to provoke *Mr. Mur* by playful antagonism.

His relevant participation with other members and the leaders has decreased, and apparently marked anxiety over the notes has disturbed his general passivity. Behaviorally he seemed adversely affected, although his only comment was, "I suppose the notes are good."

Mr. Ber's behavior seems calculated to get undivided attention from the leader. He stands outside the group most of the time and hardly ever sits down. Since the minutes have been read, he

has shown decreased verbal productions and interactions, both with other members and the leader.

His attitude seems to be one of shrugging denial. When asked if he objects to the notes, he shrugs his shoulders and says, "I don't hear the notes."

GROUP CHANGES FOLLOWING INNOVATION OF FEEDBACK

To summarize the effect of the feedback on the group-as-a-whole, the observer and the recorder concurred in the following evaluations. There were moderate increases in group cohesion, jamming, interest, member-to-member interactions, focus on the group issue, and continuity of the group issue. There were slight increases in affectional ties and anxiety. There was no change in member-to-leader interactions. There was a slight decrease in clique formation.

A substantial increase in the focus on, and continuity of, group issues was anticipated, since the feedback itself provides continuity and can constitute a group issue. The innovation introduced, as a constant experience, the very things the writers were considering as variables. Yet, the writers are reluctant to dismiss the results as altogether an artifact. This innovation seemed to produce the expected effect. Other innovations with psychotic populations do not always have the anticipated effect.

To supplement these impressions of the change in group and individual behavior associated with the feedback, the summary of the fifth meeting following the innovation is reproduced. These minutes will serve to give a general picture of the group and its members, as well as to illustrate the nature of the "feedback" material. The following, then, is a complete specimen of the notes for one meeting, taken and edited by the recorder, and read by him at the beginning of the next meeting. Names, except for the leader and recorder, are disguised.

December 9, 1955

Group Therapy

Leader, J. Golner

Recorder, H. Geddes

Mr. Mur got a light from Mr. Golner and Mr. Min asked Mr. Golner about the *N. Y. Times*.

Mr. Golner asked that the notes be read, and Mr. Geddes read them. Mr. Hen objected to one point as a lie and objected more quietly during the rest of the reading. Mr. Min denied knowing Mr. Res (not a group member) or being related to him. Mr. Hen had left the group during

the reading and now walked around near Mr. Geddes, asking what a punk was and saying, "This is your teacher, he's a beaut." Mr. Golner said he noticed that Mr. Hen objected to the notes. Mr. Hen said, "Did you notice that?" in a sarcastic tone. Mr. Min said he was not related, and Mr. Golner mentioned that he was also objecting, as Mr. Hen had objected to the part which said blood would be spilled. Mr. Min said, "No blood can be spilled, call me John Doe." Mr. Golner wondered if Mr. Stu objected too, since he had been shaking his head during the notes. Mr. Hen said that free institutions should be shut down and asked Mr. Geddes that this be written down. Mr. Min said that they were not responsible, referring to the patients, it seemed. Mr. Hen said, "We ain't? Some of the brightest people in the country are here." Mr. Min continued to object to the reference to his being related to the tennis player and said the notes could be read every day of the week as far as he was concerned. Mr. Golner mentioned the absent members and left the room.

Mr. Mur sat on a table in the rear (wearing a suit jacket today) and now spoke of some one by name and said, "You can write all you want to, I don't care." Mr. Cre sat with his back to Mr. Geddes and spoke, but could not be heard. Mr. Golner returned and asked Mr. Min why he did not use a handkerchief instead of spitting in his pocket. Mr. Min did not answer. Mr. Golner mentioned the objections to the notes, and Mr. Hen said that the stuff had gone by. The leader asked Mr. Mur if he had objected but got no reply. Mr. Hen now moved over to sit beside Mr. Cre with his back to Mr. Geddes and spoke in a low voice to Mr. Golner which could not be heard by Mr. Geddes. Mr. Golner pointed out that Mr. Hen had done that last week too. Mr. Min said, "Oh, go to hell," to the ceiling. Mr. Golner said that Mr. Hen was not the only one who spoke softly. Mr. Hen continued to speak to Mr. Golner and now asked him what his opinion was of him.

Mr. Golner asked Mr. Ber if he objected. Mr. Ber said he guessed not since he had not objected at the time they were read. Mr. Golner asked Mr. Bev who looked puzzled but did not reply. Mr. Min spoke toward the ceiling, saying that they serenaded him with sugar and hit him with mud. He said he doesn't mind the paper because his conscience is clear. He and Mr. Golner spoke of objecting. Mr. Cre and Mr. Hen spoke but could not be heard. Mr. Cos came in and said "Hello" to the group, sat down and greeted several members. Mr. Min spoke on of unpleasant news and of Mr. Res. Mr. Golner wondered if anyone would like to tell Mr. Cos what was going on. No one did. Mr. Cos spoke of leaving the hospital and of going home. Mr. Min spoke of going to see Miller Huggins in New York, when he was 22, for a job. He said he did not want to mention his name first and then mentioned it. He spoke of Toscanini and Mr. Hen asked if these were famous people. Mr. Min said, "Very famous."

Mr. Min asked that the notes be stopped and said he criticized the notes and could not apologize. He said he would stop them if it was in his power, otherwise he was helpless. Mr. Golner asked the others and then Mr. Min asked individual members if they wanted the notes stopped. Mr. Golner commended him for speaking his mind saying how he felt. Mr. Min asked Mr. Cos who answered in detail, but not clearly, mentioning a doctor, a patient and others. Mr. Min said the price was never too high and said he criticized both Mr. Golner and Mr. Geddes. Mr. Golner asked him why he criticized. Mr. Min said the notes might do damage to others. Mr. Golner wondered if others thought this was true. Mr. Cos spoke loudly and unclearly. Mr. Golner said Mr. Cos had not answered and Mr. Cos said he had answered perfectly clearly, saying, "He called you Gorman, I call you Burg." Mr. Min told the group that a vote could be taken in the group and the majority could stop the notes. He asked Mr. McK, but no response could be seen. He asked Mr. Cre who said, "Yes, he agreed to the notes." Mr. Cos said they "got to stop" and went on unclearly. Mr. Min spoke of news traveling out of here and the infringement of their rights. He asked Mr. Bev, who shook his head against the notes. Mr. Stu said the reading was all right. Mr. Min said there was a tie. Mr. Golner commented that the group was split. Mr. Min asked Mr. Ber, saying that the earth did not hold any secrets. Mr. Golner commented that Mr. Min had not asked Mr. Mur. Mr. Min turned and asked him, and Mr. Mur replied that the notes were very interesting and that he was satisfied. Mr. Min asked him if he liked to have poison hurled at him, and Mr. Golner commented that this was a loaded question. Mr. Min denied this and asked Mr. Mur again. Mr. Mur said, "Yes," and Mr. Min said he would not and spoke again of the notes as poison.

Mr. Con came in. Mr. Golner wondered why Mr. Min thought that the notes were poison. Mr. Hen said that poison was what got him in here. Mr. Min turned to Mr. Con and asked him if he would like his name prejudiced in any way. He mentioned notes being read here which brought about unfavorable publicity. He asked if Mr. Con would want such notes read. Mr. Con said he did not know what to say. Mr. Min said, "Yes" or "No." He then asked if he would want notes read if they called his cousin a bad person? Mr. Con left the group and went back to sit with Mr. Mur. Mr. Min asked Mr. Cre if he wanted the notes stopped. Mr. Cre said, "No," very emphatically adding that they seemed logical and saying they were the only logical sound in the meeting. Mr. Min asked him if he had changed his mind, and smiled. He then said, "Oh hell, I give up, normal." Mr. Con talked to Mr. Mur and kept reaching toward him. Mr. Mur slapped Mr. Con's hand, and Mr. Con smiled and finally returned to the group. There was further discussion of the notes, and there was

noise from the hall. Mr. Cos left the group suddenly, went over and closed the door, and returned quickly to his position in the group.

Mr. Con talked to Mr. Mur over his shoulder. Mr. Min spoke of protection, and Mr. Cre laughed and said they were all hot and bothered. Mr. Golner wondered why the group was all hot and bothered over this. Mr. Cos said the notes were good and stood up and talked for some time. Mr. Min again said he was no relation to Mr. Res and mentioned a write-up in *Time* magazine two years ago. He spoke to Mr. Geddes saying, "You won't listen to me, will you?" Mr. Golner said it sounded as if Mr. Min was appealing to Mr. Geddes. Mr. Min said Mr. Geddes was a fine man and went over to get some tobacco from Mr. Cos and thanked him. Mr. Cos said, "You're welcome." Mr. Cos said this was a real hospital, not G.I. There was further discussion of the notes. Mr. Cos spoke loudly and angrily, pointing to Mr. Geddes and his table and speaking of two men at a table writing. Mr. Hen walked back and forth in front of Mr. Geddes. Mr. Golner mentioned that some wanted the notes stopped and wondered why. Mr. Cos said, "Let them explain." He said that he was no fool and spoke of there being no more food and clothing if the notes were stopped. Mr. Min spoke toward the ceiling of Dr. Barton (the superintendent) and of Mr. Edg out of the State House. Mr. Mur talked but was hard to understand. Mr. Min said that everyone here is sane.

SUMMARY OF RESULTS

The principal value of the "feedback" seems to lie in its challenge to the reality sense of the patients. It confronts group members with the reality of what each one said or did and reveals their usual patterns of reacting. Such self-objectification as is mirrored in minutes provides an experience of self-confrontation which may override a patient's defense against "the shock of recognition." To see, to hear one's self as others do, is a potent experience, often a stimulus to change.

The leader and recorder have the responsibility of insuring a minimum of distortions in the summary. Encouraging the group to make corrections immediately after the reading invites members to take responsibility for what they say and do. This seems to encourage, not only the function of recall, but also that of common sense. In spite of chronic psychosis, there seems to be something left of that ego function which makes one resentful when misquoted, or quoted as saying or doing something ridiculous or logically indefensible.

Feedback also has the possibility of welding a group, because it summarizes a shared experience. Ego-involvement of persons is

enlisted by personal reference to each one's contributions, and the group aspect of the productions is kept in focus by reference to the issue at hand and to the agreements and disagreements of members.

It may be objected that this reading of the minutes distracts the group from its regular business, but with chronic patients it is often obscure what regular business is at any given time. The minutes automatically become the group issue, if for no other reason than their place at the beginning of each hour.

LEADER'S REACTION

The feedback had effects on the group leader as well as on the group members. The leader had the feeling that the feedback diminished his power, as it seemed to become a "therapist" in its own right. The leader developed strong feelings about the feedback procedure. Sometimes it was viewed as a strong ally, a powerful reinforcement. Sometimes it was viewed jealously as a competitor; and, at still others, it was felt to be threatening—especially when the leader felt his comments or responses had been inept or inappropriate. Confronted with a record of his activity in the same interpersonal network in which it was made, the leader is no longer able to distort his recollection of the proceedings by selective forgetting. He is forced to review his leadership technique critically. If he doesn't like what he hears, his resistance may be similar to that of the group.

RECORDER'S REACTIONS

During and after the initiation of the feedback, the recorder noted, first, an increase in feelings of involvement in the group. Where he had felt like a spectator; with feedback, he felt he had a share in the treatment. Recording became focused more than before on taking down as much as possible of what happened, with less focus on discerning the issues. The attempt was to get quantity as accurately as possible, in order to reproduce the total meeting at the subsequent group session. This meant some sacrifice, in observing group trends and feelings, since the job of recording usually occupied the recorder's complete attention. Even then, the recorder was not able to reflect in his summary, everything that happened. Some comments by leader and members would be omitted. The choice of omissions was, of course, a subjective one

and reflected the recorder's feelings about group members, about the leader's activities and about the importance of different events and material.

A conscious effort was made to avoid subjective descriptions and opinions in feedback. This probably resulted in some loss of reality in the feedback, since mention of many obvious feelings was omitted. The recorder did attempt to read quoted remarks with appropriate tone qualities.

The written feedback notes were open for inspection by the members, and on several occasions they were requested by, and given to, members during the meeting. They were always returned undamaged.

During the early meetings there was usually silence among members while the notes were read. If there was an interruption, due to members' arriving late or due to members' talking or yelling, the recorder usually paused until the interruption was past. Later on, the recorder stopped reading only when late members arrived. He read on, regardless of any disturbance within the group.

The recorder usually did not reply to comments or questions about the notes. If the members pressed for an answer or a comment, he attempted to make a comment which would redirect their attention to the group.

With the innovation of the feedback, recording became more significant, difficult and interesting work. Its obvious importance to the group made the recorder feel more powerful and potentially more therapeutic. When the minutes were read—condensed and selected as they were—the recorder was clearly doing something *to* the group, not merely recording *for* it.

Feelings of rivalry with the leader are induced by this use of minutes. In the present instance, the leader referred to the feedback as "becoming a therapist in its own right" or a "co-therapist." These attributes are ascribed not merely to the notes but to the person of the recorder, who thus comes to play an active role in the group process.

Boston State Hospital
Dorchester Center Station
Boston, Mass.

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THE IMPORTANCE OF NONMOTIVATIONAL BEHAVIOR PATTERNS IN PSYCHIATRIC DIAGNOSIS AND TREATMENT*

BY STELLA CHESS, M.D., AND ALEXANDER THOMAS, M.D.

In recent years the study of behavioral disturbances has been largely dominated by the psychodynamic approach. The major, though not exclusive, influence in this direction has been provided by the psychoanalytic movement, with its emphasis on the determination of various psychopathological phenomena by underlying purposes, motives and conceptualized goals and aims.

This orientation has enriched tremendously our knowledge of how much in human behavior that superficially appears to be aimless and meaningless may in reality involve patterns and structures of functioning of a purposive character. Unfortunately, however, the search for an underlying motive as the explanation for a specific item of irrational behavior has often involved the assumption that such a motive must exist. In other words, it is taken for granted that the behavior could not occur unless the individual possessed a purpose and aim, usually unconscious, which could produce such behavior. This assumption is encouraged by the very nature of psychodynamic formulations, such as repression, reaction formation and sublimation. Such concepts make it possible to explain any aspect of overt behavior as due to some postulated unconscious motive, whether the behavior corresponds to, or is opposite to, the motive.

Certain of the errors flowing from a one-sided preoccupation with psychodynamic formulations are relatively easy to detect. When the infant of a few months of age is endowed with complex ideas, such as omnipotence and guilt reactions, to explain its behavior, as is done in some of the psychoanalytic literature,¹ it is clear that this is a speculation that ignores the fact that the development of cerebral functioning of the young infant cannot even approximate the level where such ideation is possible. When the motive-searching diagnostician ignores the possibility that physical illness may cause disturbances in behavior, the errors in diagnosis eventually become evident. When the therapist who is preoccupied with finding unconscious motives for all behavior tells

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the patient that his conscious solicitude and interest in his family must necessarily be a reaction-formation against an unconscious wish to injure those he loves, the destructive effect of such an interpretation is not obscure.

What is usually not so evident is that the psychodynamic bias, the demand that behavioral disturbances be interpreted in terms of some underlying determining motive, may hinder or even prevent the giving of serious attention to the nonmotivational determinants of behavior. If the study of disturbed behavior is approached without any assumption that it must always be purposive in character, then it becomes possible to delineate various non-motivational patterns.

Levy² has called attention to one such category that he has called "capacity... the individual's ability, fitness and endowment." He describes limitations of capacity due to the underdeveloped level of conceptualization of a normal two-year-old child, as well as those due to specific effects of brain injury in other children. He indicates how errors in diagnosis could be and were made, if such limitations in capacity are interpreted as purposive behavior. Levy also suggests that there may be individual intrinsic differences in the capacity for mothering, quite like the distribution of IQ's, and that such variations should not be interpreted as due to the level of desire for the maternal role.

Various other workers have indicated that specific, stable patterns of motility,³ perception,⁴ autonomic responses⁵ and biochemical functioning,^{6,7} that are determined on a physiological, nonpurposive basis, may exist in different individuals. As several of these authors have suggested, it is possible that such physiological patterns may have a consistent, long-term effect on behavior, with an influence on its structure and direction.

The authors of the present paper have been engaged in a longitudinal study of child behavior since March 1956. A total of 85 children are being followed, including a previous group of seven children who have been observed from birth onward, and now range from eight to 14 years of age. The methodology and scheme of classification of the data have been reported previously.^{8,9} The material for the behavioral analysis is obtained by detailed histories taken in a specific, objective and factual fashion from the parents at frequent intervals, plus, in most cases, periods of direct observation of the child's behavior. The classification involves:

(1) the quality of responses; (2) the manner in which consistent, long-term responses are developed; (3) the modifiability of responses; (4) the general activity level; and (5) the threshold of sensory responses.

The quality of response is either positive, negative or neutral as regards individual items of behavior. Positive responses involve behavior oriented toward a continuation of involvement with the stimulus and/or reactions indicating pleasure. Negative responses involve behavior oriented toward a discontinuation of involvement with the stimulus and/or reactions indicating displeasure and discomfort. Neutral reactions are those which do not show either positive or negative features. Positive and negative responses are also characterized by differences in intensity—quiet, moderate, intense—and by whether the total behavior shows a predominance of either positive or negative responses. In some babies, responses tend to be differentiated, with varied gradations with different stimuli, while in others there tends to be one level of intensity of response.

The manner in which consistent, long-term responses are established also varies greatly from infant to infant. Some babies show a clear-cut definite response to a new stimulus which in general indicates the character of their subsequent response to that stimulus. In others, the first responses may be stereotyped or irregular and shifting, and the long-term response only becomes evident after a number of contacts with the stimulus. In one of the children, the initial response to a new situation has shown a special stereotyped character. This has involved not only intensely negative responses to new situations but a tendency toward a disorganization of previously established patterns. With continued contact, an adaptive response to the new situation finally emerges, together with a reintegration of the disorganized functioning. This was true in feeding and sleeping in early infancy, in first experiences in nursery school, in summer camp, in moves to new neighborhoods, and in a new type of learning situation in a special progress class in junior high school.

The modifiability of responses involves several aspects. In some infants, responses and routines, such as sleeping and feeding schedules, or dislikes of certain foods, can be quickly and easily changed by parental efforts. In others, responses once established are tenacious and difficult to modify. Some babies are easily dis-

tractable, so that a negative reaction, such as crying with hunger, can be easily modified by playing with them. At the opposite extreme, are the babies whose responses are diverted by a new stimulus only with difficulty and persistent effort.

Two additional categories of reaction can be delineated from the data. One involves the classification of the general activity level, the two extremes being the hyperactive and the passive child. The other is the threshold of sensory responses, that is, the intensity of sensory stimulation required to elicit a reaction from the organism.

The data indicates that each child has a specific type of reaction pattern to environmental stimuli, which shows itself in the first few months of life and which persists in a stable, consistent form throughout infancy and later childhood. Because of differences in life situations and levels of maturation as the child grows older, the same reaction pattern will show itself in very varied forms in actual behavior at different age periods. A qualitative analysis of all the records, and a quantitative item analysis thus far completed in 22 cases, indicates a high order of correlation in the consistency of the reaction pattern in each child at different age periods.

The available evidence, though as yet scanty, suggests that these patterns are inborn and not experientially determined. In any case, their appearance within the first few months of life before the infant is capable of forming any purposes or aims involving conceptualization means that these reaction patterns must be determined on some physiological basis. If the possibility is not considered that such non-purposive reactions may exist in the older child and influence the character of some of his behavioral responses, then it is likely that the error will be made of taking an exclusively psychodynamic approach to the analysis of such behavior. A few brief examples will be given. One girl has shown since early infancy intense negative reactions to the first contact with most new stimuli. This has persisted as she has grown older, so that at five years any injury or bruise, even very minor, elicited an immediate and loud, but brief, period of crying. Other annoyances and frustrations at various age periods also occasioned sharp and intense negative reactions when they first occurred. The search for purpose would have led to the assumption of some unconscious reservoir of hostility which was triggered off and

brought to consciousness by various events. The writers have seen this kind of interpretation made to explain similar behavioral responses in adults, where the evidence actually suggested a greater likelihood of this type of intrinsic high-energy emotional response rather than any unconscious store of hostility. Another child's reactions since infancy have been characterized by a predominance of mild, positive responses to various situations. As he grew older this meant that he showed little or no disturbance, and, therefore, a lack of involvement in all sorts of petty or minor annoyances and difficulties created by other children. His mother, a professional worker in a psychiatric field, has interpreted this lack of anger and combativeness in such situations as being due to timidity and cowardice.

The ease or difficulty an individual child has in learning, whether in toilet training, school situations or athletics, may be determined, not only by his motivational level, but also by the character of his intrinsic reactions. Some children develop clear-cut, consistent and long-term patterns slowly and with difficulty, in contrast to others who form such patterns easily and quickly. This can be seen in the establishment of regular schedules in feeding and sleeping in early infancy, in the responses to play situations and initial situations of discipline and socialization at the one-to-two-year-old level, in the ease with which toilet training is developed, as well as in the more complex social and learning situations of later childhood. It is easy to misinterpret the reactions of the child who establishes patterns slowly and with difficulty as representing a motivated resistance or reluctance to learn. Such an interpretation by parents or teachers, expressed in a critical fashion to the child, may actually stimulate the secondary development of such resistance and dislike for learning, which may then be interpreted by the psychiatrist as the primary factor.

It appears to be a tendency of the human mind to explain obscure and unclear phenomena in motivational terms. Primitive man explained earthquakes, floods, disease and all sorts of other natural phenomena as the expressions of the purposes of the gods. Piaget, in his studies of the thinking of the young child, finds that, "The idea of the fortuitous does not exist; causality presupposes a 'maker,' God, the parents, etc., and the questions refer to the intention which he may have had. . . . Organic life is, for the child, a sort of story, well regulated according to the wishes

and intentions of its inventor... Causal explanation and logical justification in particular are still entirely identified with motivation."¹⁰

The adult in present-day society may be clear that natural phenomena are not caused by human purposes, but he does tend to assume that behavior is so produced. Even the functionings of animals and plants are commonly designated by motivations. A bee "seeks" food in a flower, a caged bird "wants" its freedom, the roots of a plant spread out "in search" of water. With human behavior, the motivational explanation is ubiquitous. Psychiatric patients constantly formulate explanations of the obscurities of their own behavior, and of that of other people with whom they are involved, in terms of some underlying purpose.

The psychiatrist who automatically thinks along similar lines may not be able to help the patient correct such judgments when they are inaccurate and destructive. As an example, one patient came to his psychotherapeutic session one day with the statement that an incident had occurred the night before which indicated that his wife really did not wish to work out the problems which were seriously disturbing their relationship. He had suggested to her that evening that they should sit down and discuss these problems. She agreed promptly and said that she could do it as soon as she had finished putting the children to bed. She went upstairs and he waited for her, busying himself in the meantime with work of his own. After several hours he suddenly realized that she had not come down and that it was now too late in the evening for the discussion. He went upstairs and found that she had been absorbed in various routine chores. She expressed surprise at the passage of time, and insisted that she did want the discussion. However, he felt that her behavior could only be due to a resistance to the consideration of their problems and indicated this to her. After reporting this incident with his derogatory evaluation of his wife's motives, the question was raised with him as to whether his wife showed any difficulties in estimating the passage of time in other situations. He immediately recalled that this was a chronic problem of hers, that she was always making gross errors in time judgments, even when there could be no doubt of her desire to be punctual. This difficulty of hers was actually a long-standing joke in her family, going back to her girlhood days. It became clear that her behavior the night before was much more likely due to

this problem with time estimation, rather than to any desire to avoid a discussion, and this interpretation was confirmed by subsequent events. It was also evident that if his derogatory judgment of her had not been questioned, it would have served as a further stimulus to the disruption of their relationship.

This kind of immediate assumption of undesirable motives as necessarily underlying behavior which is not optimal in a particular situation is a characteristic attitude of patients in psychotherapy. This assumption involves the question of their own behavior, as well of their spouses, children, parents, friends or co-workers. Sometimes they are right, at other times the motives may be there but misinterpreted. In the writers' clinical experience, however, there are many situations in which such judgments of purpose are made where the behavior in question is actually determined by limitations of capacity, intrinsic reaction patterns or unrecognized physical illnesses. Where undesirable motives are incorrectly ascribed to the other person, this frequently leads to deterioration of the interpersonal relationship. Where they are ascribed to himself by the patient, they lead to increased feelings of guilt, anxiety and inferiority.

The detection of a nonmotivational behavior pattern does influence the approach to treatment. Where disturbed behavior is due to an underlying purpose, the direction of treatment usually involves the attempt to change or modify this motive in such a way that the undesirable behavior will be altered. If, however, the behavior is nonmotivational in character, a search for an underlying purpose will be fruitless. The approach to therapy in such situations should be different if it is to be effective. What is necessary is a modification of functioning so that the destructive aspects of such a nonmotivational pattern are minimized and so that it is channeled as much as possible in constructive directions. Where a limitation of capacity exists, such as sensory defect, mental retardation, or impulsive and un-co-ordinated behavior due to brain injury, psychotherapy should be integrated into an overall program of training and rehabilitation.

Where an intrinsic reaction pattern or special motility or perceptual functioning produces behavior which in one way or another is undesirable, effective treatment must start from the understanding that such behavior is not due to unhealthy and destructive purposes hidden within the patient. The delineation of this fact is

itself of great value in relieving the guilt and self-derogation of the patient, or the anxiety and condemnation of the parent if a child is involved. The patient or family should then be guided in the development of responses which will minimize the undesirable effects of the pattern. For example, a girl with immediate intense emotional reactions to new situations had difficulties when a negative response resulted either in withdrawal from the situation or the expression of excessive irritation and antagonism, which alienated other people. This patient had to learn to inhibit such undesirable expressions when she experienced an initial, intense emotional reaction and to wait until this subsided before involving herself in a behavioral response to the situation.

A boy who formed long-term patterns slowly and irregularly, with consequent difficulty in achieving a mastery of various learning situations, felt that he was "stupid" and "couldn't learn." An approach to this problem involved an insistence on frequent and regular drilling, with the demonstration that this did result in effective learning with no evidence of intellectual deficiency.

The parents of a hyperactive, hypermotile three-year-old child tried to set limits for his physical activity appropriate to the level of the average child. They became involved in constant attempts at prohibitions and restraints of his activity, with negativistic responses by the child, followed by the development of hostility and guilt feelings in the parents. Treatment involved, first, the achievement of an understanding by the parents of the intrinsic character of this extreme motility pattern and the necessity for their acceptance of it as an integral part of their child's functioning. A program involving the restriction of prohibitions to a minimum of essential issues and the channeling of the child's activity into various constructive play situations was developed. This resulted in the disappearance of the negativism in the child and of the hostility and guilt in the parents and the development of a healthy, positive parent-child interaction.

This report has focused on various types of nonmotivational behavior patterns and their importance in both diagnostic evaluation and treatment. This is not to question the fact that conceptualized purposes and aims play a vital role in the development of human behavior and psychopathology. The issue is whether these psychodynamic forces are always and necessarily the exclu-

sive determinants in a patient's psychological disturbance or whether factors on a nonmotivational level may not also be important in many cases.

SUMMARY

Behavioral disturbances may involve not only motivational forces in the form of purposes and conceptualized goals and aims, but also nonmotivational factors. These latter include limitations in capacity, such as the results of incomplete maturation or brain injury, specific patterns of motility, perception or biochemical functioning, and various types of consistent, stable, intrinsic reaction patterns. The lack of recognition of such nonmotivational factors, when they exist, and the incorrect assumption that the behavioral disturbances are the exclusive result of underlying purposes can lead to significant errors in diagnosis and therapy.

1165 Park Avenue
New York 28, N. Y.

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THE OFFICE MANAGEMENT OF THE NEUROTIC PATIENT*

BY WILLIAM MALAMUD, M.D.

It is a matter of general medical experience that the patients who are usually referred to as "neurotic," form a very large, if not the largest, group seen in general practice or in out-patient departments of general hospitals. It is also true, however, that the label "neurotic" is more frequently used as a description of the patient's character, with a liberal admixture of skepticism as to the reliability of his complaints, than as a medical diagnosis based upon a definite concept of specific etiology or of a characteristic symptom complex. Because of this, any discussion for the nonspecialist of the management and treatment of the neurotic patient in general practice should be prefaced by a brief—even if, of necessity, sketchy—statement concerning the fundamental factors that lead to the development of these conditions, and a definition of the clinical syndromes that are characteristic of them.

It is well to emphasize to general practitioner or student that within recent years it has been demonstrated through clinical experience and experimental investigation that social and psychological stresses, depending upon the degree of intensity, the frequency of the impact and the nature of the personality involved, can and do give rise to illnesses which may seriously interfere with a person's adjustment. The symptoms of many of these diseases are primarily manifestations of behavior disturbances and psychological abnormalities. It is true, however, that these conditions may almost as frequently give rise to histologically or biochemically demonstrable disturbances of bodily function. At times, these disturbances are due entirely or largely to psychogenic factors; at other times, these factors may serve to intensify or perpetuate symptoms, which have been started by some organic noxious agent. It is, furthermore, important to recognize the obverse of this process: namely, that pathological conditions originally caused by organic factors, may have as one of their effects a change of behavior leading to psychological maladjustment. In both of these conditions, one must, in addition to recognizing and treating the organic pathology, also gain an adequate

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understanding of the behavior problems and deal with them on the basis of attacking the causative factors.

Along with the recognition of the importance of these factors in the development of such illnesses, it has also been learned that the appreciation by both the patient and his physician of the nature of the stress situations that have produced the symptoms and the manner in which these situations and symptoms are interrelated, can be highly effective in the treatment and management of the patients. The experiences which originally gave rise to the development of the stress situations may have occurred years before the onset of the symptoms, but may have remained "dormant" until they were reactivated by an apparently innocuous event. This has made it necessary to devise techniques to help the patient recollect such events and realize their relation to the symptoms.

In teaching, one could, therefore, define a neurotic illness as one in which the predominant symptoms are largely or wholly conditioned by environmental or emotional stress and resultant psychic conflicts. These symptoms are either expressions of the conflict itself, or they represent attempts on the part of the organism to defend itself against the conflict.

The variety of symptoms that can develop on this basis is extremely broad, but they can all be generally classified as belonging to one or more of the following groups:

1. *Conversions.* Conversions are somatic symptoms referable to the sensory, motor or visceral organs, but not accompanied by demonstrable organic pathology. Examples of these are various degrees of disturbances of vision or hearing, partial or total loss of voluntary movements, anesthetics, analgesias, bladder disturbances and numerous other manifestations. In distinction to organically-caused disturbances of such organs or functions, the topographical distribution of conversions is symbolic (i.e., it represents an idea of function), rather than segmental or anatomical. Thus, it is that one finds such symptoms as glove and stocking anesthesia, or flaccid paralysis with hyperactive reflexes. Generally speaking, these symptoms are referred to as "hysterical."

2. *Psychosomatic Illnesses.* Psychosomatic illnesses are somatic symptoms which also develop as reactions to conflict-producing stress situations; but, unlike conversions, they are accompanied by either transitory or lasting, demonstrable tissue pathology.

The incidence of this type of illness is very high, and a wide variety of organs and functions may be affected. To this group, belong some gastro-intestinal disturbances (such as colitis and spastic conditions), cardiovascular disturbances (such as hypertension), bronchial asthma, skin lesions, and endocrine disturbances. In many of these conditions, one finds that the major causes are entirely psychogenic; other disturbances may be the results of the superimposition of psychological stress on conditions originally due to organic causes. Furthermore, in some cases where illnesses may have started on a psychogenic basis, but have been allowed to go on for long enough periods, the resulting pathological disturbances may in themselves lead to secondary organic sequelae.

3. *Compulsive Symptoms.* Compulsive symptoms are psychological disturbances which also develop on the basis of stress-conditioned conflicts, and are characterized by forms of behavior which the patient experiences as being imposed upon him by some mysterious force within him. They may be manifested by compulsive thoughts (obsessions), or acts (compulsions), or feelings (such as phobias). They are frequently classified under the term, psychasthenia.

4. *Faulty Control of Emergency Measures.* A number of pathological disturbances of behavior may be considered the result of faulty control of emergency measures. Normally, human beings, in common with other organisms, possess a variety of emergency measures with which they react to stress situations. Thus, there is, for example, anxiety as an emergency reaction to vital danger, fatigue as a reaction to prolonged and extreme exertion, and so on. These may be considered normal behavior manifestations when they are in keeping with the reality and intensity of the emergency. It is found, however, that as a result of certain types of stress-conditioned conflicts, anxiety may be experienced without consciously-appreciated real danger, or fatigue without preceding exhausting activity (anxiety neuroses, neurasthenia, etc.).

This is an admittedly sketchy description, outlined for teaching purposes, of the types of symptom complexes that may be classified as "neurotic." They can occur in any one of the foregoing groups, or in a combination of two or more of them, or, finally, in combination with manifestations of other disease processes (organic diseases, or psychoses). Since these neurotic symptoms

are dependent primarily upon environmental or emotional stress and conflicts resulting from them, the treatment and management should be directed toward ascertaining the nature of the conflict and the stressful experiences that produced it, and then helping the patient face them adequately. It is this method of treatment and management, generally designated as "psychotherapy," that will be discussed in the succeeding paragraphs, in terms of the *goals* that are set and the *methods* that are available for attaining them.

GOALS OF PSYCHOTHERAPY

1. *Understanding of Relationships.* If one accepts the fact that emotional conflicts based upon stressful psychological and social experiences have played an important role in the development of these illnesses, whether they are manifested by physical or psychological symptoms, it is natural to ask the question as to what is the nature of these causative factors and what is their relationship to the illness with which we are dealing? The answer to this will provide the fundamental material for the treatment; and the understanding of these relationships, therefore, becomes the first goal. This is, of course, true in the practice of any form of treatment; but in these "neurotic" conditions, there are certain factors which are specifically more important than others and, therefore, should be more firmly emphasized. For example, definite information is needed about the social setting, the family situation, and the personal attitudes and experiences of the patient at the time when the symptoms first appeared. Can any clear-cut relationship be shown, either in time or content, between the problems in these areas and the development of the first signs of the illness? Was the patient faced by some special stress situation at the time of the onset? Did the course of the illness, in its remissions and exacerbations, bear any logical time-relationship to the rise and fall in the severity of these personal difficulties? Were the symptoms in any way useful in bypassing these psychological problems, or did they help the patient to escape the necessity of dealing with them? In other words, has this illness, even though it has incapacitated the patient, also served as an escape mechanism?

This means that one has to undertake a systematic study of the background that preceded the onset of the illness. The therapist must find out whether there were any experiences in the patient's

life which have rendered him susceptible to, and less able to deal with, the type of stress situation which he had to face at the time of onset of his illness. Similarly, it is important to find out whether anything has occurred in his life which has predisposed him to react to stress situations of this type with the particular form of symptoms that he now demonstrates. Is it possible that patterns of this type have been established in the family or in the wider circle of the patient's social environment? Were there frequent occurrences of such disturbances in members of his own family, and have they tended to develop under conditions similar to those characterizing the problems under which the patient was laboring at the time of the onset? This means that a thorough knowledge of the family constellation and of the early home setting is essential to determine the presence of either constitutional predispositions or the conditioned establishment of certain patterns of reaction.

It is well to remember that in treatment of this type, the very search for such relationships forms in itself, part of the therapeutic process. In the first place, the patient, as he recounts these experiences, begins to understand the reasons for the development of his symptoms and thus can begin to approach a more realistic solution of his problems. This means that it is highly important that, not only the physician, but also the patient, develop a clear understanding of these relationships. Second, as the process of the discussion of the life situation of the patient progresses, the patient cannot help but develop a strong emotional relationship with the physician. The latter becomes a friend, a sympathetic listener, a person interested in the life and experiences of the patient and this sets the stage for the second important goal in this process.

2. Patient-Physician Relationship. By the patient-physician relationship, is meant the establishment of one which, among other things, will assure the emotional participation by the patient in the process of the treatment. It is important to keep this goal in mind, because very frequently some of the problems that are involved may be so near the surface and so obvious to the physician, that he may be tempted to seek short-cuts through explanation to the patient of the meaning of the symptoms. Experience teaches, however, that unless the patient brings forth these experiences himself and gains emotional as well as intellectual insight by actu-

ally reliving them, the results are either not obtained at all or remain on a verbal level without any enduring effects. As the work with the patient progresses and as he develops the proper feeling of confidence in the physician, it becomes possible for him to identify the physician with the persons who played the important roles in his early life, but who were also threatening to him and, thus, conditioned him to react pathologically to the settings in which he was at the time. By virtue of the fact that the physician remains sympathetically understanding and, at the same time, objective, it is possible for the patient to break through these patterns and learn how to meet life situations by taking them at their face value, rather than by associating them with early traumatic experiences. This makes the process of treatment more time-consuming, but the results are also more effective.

3. *Removal of Some of the Causative Factors.* Understanding of relationships acquired in the atmosphere of a proper patient-physician rapport will help the patient to evaluate his problems more clearly and enable him to formulate methods of dealing with them without having to take recourse to his symptoms. It is also quite clear that some of the actually existing social and psychological conditions in the present setting may be largely responsible for at least some aspects of his illness. The presence, for instance, of incompatible family relationships or threats of loss of economic security, may in themselves tend to perpetuate the utilization of symptoms as an escape mechanism, even though the patient understands the relationship between the stress and the symptoms' formation. This makes it important, therefore, for the physician to try to lessen the actually existing irritating factors in the setting.

The therapist must also keep in mind the importance of dealing with complications introduced by symptoms that are either secondary to the original illness—or are due to an unrelated, coincidental factor. The former situation is particularly likely to occur in some of the psychosomatic illnesses, when there may be complications such as secondary infections in an irritating dermatitis, or inflammatory lung diseases developing in a person with asthma. This observation also applies to such conditions as lowered resistance produced by irregular diet and other metabolic disturbances in gastro-intestinal diseases, or lack of muscular exercise in arthritic conditions. These must all be treated, even if only symptom-

atically, at the same time that the physician is attempting to remove the cause of the original disease. In carrying out this aspect of the treatment, one must make use, not only of general medical therapy, but also of any assistance that can be obtained from outside sources. The family and social agencies may be very helpful in reducing undesirable social and economic stress. The minister, lawyer, schoolteacher or employer may all have to be called on to assist in making the patient's situation as easy to adjust to as is possible under the circumstances. The patient, whether he is suffering from a physical or neurotic illness, cannot be treated in a vacuum, but only within the general family and community setting in which he lives.

4. *Emancipation and Readjustment.* Treatment of this type, as was pointed out in the foregoing, involves the establishment of a special relationship between the physician and the patient. As the patient is encouraged to discuss some of his most intimate problems and conflicts and is encouraged to bring up early childhood experiences, he cannot help but develop a great deal of attachment to, and dependence upon, the physician himself and the therapeutic setting in general. It is a well-known fact that under such conditions, the patient may become so dependent upon the physician that even if he has succeeded in ridding himself of his symptoms, he may have lost his ability to adjust himself on an independent level. This circumstance actually may turn into one of the most trying developments in the course of working with such patients, if—from the very beginning of the treatment—the physician does not make the eventual emancipation and readjustment of the patient to an independent life one of the important goals in his program. This process of emancipation should, therefore, be kept in mind from the very outset, and the ground must be prepared gradually for the patient to be able to break away from his dependence upon the physician.

These, then, are the goals toward which we strive in working with neurotic patients. It is obvious that the degrees of achievement of these goals will vary. It is probably true that under no circumstances, even with the most complex methods of therapy, can these goals be attained with perfection. Sometimes one has to be satisfied with partial achievement, and it must also be remembered that in this type of treatment, just as in any other therapeutic process, even the most far-reaching results may leave

the patient with some degree of defect, just as no operation can be performed without leaving some scar. For the achieving of these goals, the following methods are available:

PSYCHOTHERAPEUTIC TECHNIQUES

1. *Exploration.* Exploration includes the various procedures which are used in obtaining the background material, both from the patient and those about him. Insofar as the physician is concerned, the most important source for such material is the patient himself and this is obtained through appropriate "interview technique." The interview, however, is not only exploratory; it serves several purposes. In the first place, it is, of course, informative; that is to say, it provides both the patient and the physician with an appreciation of the nature of those factors that were responsible for the development of the illness and the experiences that led to it. In other words, it should provide the physician with an adequate history. Second, it presents the physician with an opportunity to observe the reactions of the patient, both verbal and nonverbal, as he recounts his experiences; in other words, it helps in the process of diagnostic evaluation. Third, it plays an important role in the treatment because it facilitates the establishment of the proper patient-physician relationship; and, at the same time, as the story of his experiences unfolds, the patient begins to gain insight into the relationships between these experiences and the problems that have developed.

These three functions of the interview cannot be regarded as isolated goals, which are achieved in some specific chronological sequence; they all are sought simultaneously. This means that, in conducting an interview, one does not concentrate entirely on any one of these goals to the exclusion of another, but aims at an integration of all of them. The therapeutic process, for instance, may start even before much of any verbal exchange has taken place between patient and physician. The attitude which the patient brings with him to the physician's office, the impression that the latter makes on the patient, the manner in which he shakes hands, his facial expressions, all of these begin to set the stage and serve to establish the atmosphere that may determine the relative degree of successful achievement of all the goals.

A comprehensive presentation of the interview techniques in medical practice in general, but particularly in the management

of neurotic problems is not possible in a brief statement of this type. However, it is important to discuss here some of the fundamental principles involved. Since one of the primary purposes of the interview is to furnish intelligible and reliable information to the physician, as well as to the patient, it is highly essential that both of them clearly appreciate the ultimate source of such information. Thus, one of the first requisites, in regard to information that the patient gives to the physician, is that material should actually come from the patient and should not be either supplied or altered by the physician himself.

On the face of it, this sounds so self-evident that it should need no further elaboration. It is surprising, however, how very frequently the attitude, wishful thinking, or fantasy, of the physician may be projected into the material, which is supposed to come from the patient. The manner in which the physician phrases a question, or the comments that the physician may make in response to a statement by the patient, even such nonverbal items as changes in facial expression, the shrugging of a shoulder, the raising of an eyebrow, changes in intonation of the voice, all of these may not only influence the manner in which the patient produces the material, but may actually suggest content which represents the physician's guess, rather than the patient's memory. It is obvious that these possibilities must be considered seriously if one is to get an authentic historical statement from the patient, since the physician's guess may, of course, be wrong—without either patient or physician realizing it. Even where a suggestion from the physician may result in the bringing up of an actual experience in the life of the patient, the desired effect of the uncovering of such an experience, which is so important therapeutically, may be missed because it comes at the wrong time or within the wrong context.

All of this, therefore, means that in the course of an interview it is highly desirable that the physician maintain a permissive attitude, and this is not always an easy task. The patient should be given an opportunity to express himself freely, even if this takes longer than is compatible with the physician's patience. Directive questions by the physician should be at a minimum, so as not to interfere with the free flow of productions from the patient. It is true that certain direct questions have to be asked in the course of a systematic history-taking, but it is best to put

them early in the interview, and preferably in relationship to more or less indifferent material.

Since this is a to-and-fro process, it follows that similar considerations also apply to whatever information the patient obtains from the physician—in that such information should actually come from the physician and not be products of the patient's fantasy or projections. The material which the physician will want to impart to the patient is, of course, much less extensive than that which comes from the patient to the physician. It usually deals with information concerning the nature and probable course of the disease, directions in regard to treatment, evaluation of the prognosis and, to a much more restricted extent, advice on how to deal with certain practical problems.

One particularly important aspect of this phase of the interview is related to the variety of questions that the patient may pose to the physician; and it is well to keep in mind the fact that these questions are frequently asked on the basis of motivations which neither the patient nor the physician may be aware of at the time. There are a number of categories of these questions, each one of which may have to be dealt with in a specific manner. There are questions that the patient asks the therapist in his capacity as a physician. If a medication is prescribed, he may ask for directions as to how, at what time, and under what conditions to take it.

If the patient develops some new symptoms or signs, he may want to know what they mean, how serious they are, and so on. Such questions should be answered by the physician without any equivocation. One cannot turn the questions back to the patient or ask him why he wants to have answers, since it ought to be obvious that the patient is justified in asking the physician for explanations of such technical matters. Frequently, the physician may not be able to answer these questions without further study. If this is so, he should explain it to the patient. Furthermore, where he knows the answer, he may have to couch it in terms which are in keeping with the patient's age, cultural background, education, and whatever state of emotional turmoil the patient may be in at the time. It is important to emphasize that honesty, objectivity and understanding of the patient's condition are important guides in formulating the answers to such questions.

An altogether different problem comes up in relation to a category of questions which the patient may frequently present to

the physician, but which only the patient can and should answer. These are particularly likely to come up in disturbances that are largely emotional in origin. Questions in this area may deal with requests for specific advice as to how to deal with some particular problem, or how to act in regard to some special person. They may also refer to a variety of attitudes and sentiments that the patient may have come to discover within himself, and may have come to realize how they affect his behavior, and, therefore he will ask for instructions as to how to behave under such conditions.

It is well for the physician to make plain to the patient from the very beginning that questions of this type can only be answered by the patient himself on the basis of the material which he produces. The physician will offer to help the patient in bringing this material to light and in clarifying its relationship to the problem, but the final answer, in regard to its solution, must come from the patient himself. The reasons for this are obvious. First, the physician may actually be wrong about the adequacy of his answers. But even more important, is the fact that the patient must, in the course of time, learn to be able to deal with such problems himself; and the process of learning must take place as part of the treatment. This is particularly important, as will be seen later, in the development of an atmosphere which will make it less difficult for the patient to emancipate himself eventually from dependence upon the physician.

Finally, there is a third category of questions which the therapist could answer, but only as another person, and not as a physician. These frequently refer to such personal matters as the age of the physician, whether he is married, what his philosophy of life or religious beliefs may be, and so forth. All of these, the physician could answer if he chose to do so. However, there is no therapeutically valid reason why he should answer them, and the best way of dealing with such a question, is to ask the patient why he wants an answer to it at that particular time. In response to such an inquiry on the part of the physician, a number of reasons may come to light, the realization of which may prove to be of definite value in the course of treatment. Sometimes such a question is asked by the patient in order to "change the subject," so to speak, perhaps because the subject is a painful one. At other times, the patient does this in order to turn the tables on the physician and interfere with the process of the interview.

Sometimes a question may even represent a means of expressing aggressiveness and hostility toward the physician. The physician must not be afraid to have these reasons brought to the surface; and he should always try to make the patient appreciate the reasons why the question was interpolated, and then proceed to turn the direction of the interview back to the patient's problem rather than to the personal affairs of the physician.

Very frequently the experiences, which have led to the development of symptoms, may be partially or wholly repressed by the patient, and certain techniques have to be utilized to help the patient get at the hidden material. This is not an easy thing to do in the course of everyday treatment in general practice, but some of the techniques utilized in the more complex methods can also be used here. One can take advantage of slips of the tongue or accidental acts, memory lapses in regard to important events which should be remembered clearly, repeated cropping up of some experience or reference to a special person throughout the interview; fretting at the interview lasting too long, while the patient has been talking about some special problem; failure of the patient to come to the interview on time, following a previous discussion of what may have appeared to be an unimportant event. These matters and similar clues can be utilized as indications of the material that the patient tends to repress.

Dream analysis is of great value in pointing out such underlying factors. Although deep analysis of dreams may present some difficulties to the uninitiated, some dreams may, nevertheless, point so clearly and obviously to a repressed conflict that even the patient, after he has related the dream, will sometimes offer a more or less suitable interpretation of it. Under certain conditions and with some degree of experience, physical agents such as drugs may be used to facilitate the bringing up of suppressed material. Sodium amytal or sodium pentothal have been used extensively for this purpose, and, more recently, "tranquilizing" drugs have been successfully utilized in this manner. Experience has shown that these drugs, when used with proper precautions and adequate understanding on the part of both patient and physician, may help, not only in making it easier for the patient to bring up material which he would otherwise repress, but also in helping to establish the type of emotional response to the physician which is so essential in treatment of this type.

Here it is also well to keep in mind the fact that communication between the patient and physician during the interview includes not only the spoken word, but also a variety of nonverbal means of expression. Just as the physician will watch the patient's expression for indication of such emotions as anxiety, sadness, amusement, bewilderment, or hostility, in order to evaluate the meaning of the material, so will the patient, too, watch the physician for signs of his reactions. Any indication of disapproval, anxiety, ridicule or, on the other hand, sympathy, and willingness to help will be promptly picked up and will certainly have an impact on the relationship established and the results obtained. Because of this, it is well to keep in mind that it is highly important for the physician to maintain an attitude of professional objectivity, along with indications of his interest in the patient's problem and willingness to help him. It is not advisable for the therapist to bring himself into the picture as an individual and thus personalize the interview. The habit that some physicians have of setting themselves up as paragons of ideal adjustment, or of relating to the patient experiences of their own which are in some way similar to those that the patient has talked about, is of no help to the patient and may actually hinder the establishment of a proper emotional rapport. This then brings up a discussion of some of the techniques that may be used in the establishment of a proper patient-physician relationship.

2. *Emotional Participation.* To a large extent the techniques which can be used for the purpose of securing emotional participation on the part of the patient have already been presented in discussing interview techniques. The most important item to consider is that of the development of a setting in which the patient has the greatest possible confidence in the physician. This requires a good deal of self-discipline and control on the part of the physician. He must follow fairly strict rules of honesty, as far as the patient is concerned. He should not reveal confidences that the patient gives except by permission of the patient himself. In order to feel free to bring up personal material, the patient must have complete assurance that it will remain between him and the physician.

The physician must also be sympathetic by which it is not meant that he must "spoil" the patient or express pity for him, but that he must be earnest and sincere in dealing with the problems

that the patient brings up. He must also refrain from either ridiculing him or sermonizing to him. It is well to maintain an attitude of objectivity and urge the patient to work hard in an effort to understand how his problems have developed and what issues he must meet if he is to adjust himself as a grown-up person. As will be seen in subsequent paragraphs, this will be of great help in the process of emancipating the patient from his dependence upon the physician. For this purpose, as has been mentioned, the patient must be encouraged to make his own decisions, particularly when he actually seeks advice about matters that he should decide himself. Counseling is indicated only in situations where technical knowledge is required; where the personal interests of the patient are concerned, he should be urged to take stock of relationships within the situation and come to the conclusion that is most suited to his own way of living. Throughout the treatment, the patient should be taught to apply what he has learned, to everyday problems. At the same time, it is advisable to secure the assistance of others in the patient's setting to help him make the situation more tolerable to himself. At this point, one may consider the techniques to be utilized in the attainment of the third goal, the removal of a variety of causative factors.

3. *Utilization of Outside Resources and Other Therapeutic Measures.* The fact that the patient cannot be successfully treated in a vacuum has already been referred to. The physician should make himself thoroughly cognizant of the variety of conditions that exist in the patient's life and that may have a bearing upon his problems. Frequently, it is impossible for the physician himself to achieve this without outside help. For this purpose, it is especially important to utilize where possible, the assistance of social workers and social agencies, relatives, neighbors, friends, spiritual advisers, and others. The patient lives in close relationship to his community setting, and his ultimate adjustment will have to be to that setting. Anything that can be done by the physician—or by those who are willing to help him—to facilitate that adjustment, will go a long way in rendering the therapeutic process successful. The physician must also bear in mind the fact that no treatment of any illness can be carried on without consideration being given to the patient in his adjustment as a total person. The physical status of the patient, as well as the possibility of pathogenic factors in his physical environment, must be ade-

quately evaluated; and, if any relevantly related or even coincidental symptoms are present, they should be treated, so as to enhance the patient's assets and his ability to deal successfully with his problems. It has already been noted that the utilization of certain drugs may actually help in the development of a proper emotional rapport and in the ability of the patient to express himself freely without any resistance. It is also true that some of these therapeutic agents may help in allaying symptoms such as sleeplessness, pain, tension, irritability, and fatigue. Even if the relief here is primarily symptomatic and the basic causes must be looked for even after the symptoms disappear, it should be remembered that the removal of interference with the patient's adjustment that can be obtained through the use of these adjuvant measures, helps in securing the patient's interest, attention and co-operation in the process of treatment.

4. *Emancipation.* In the early stages of this type of treatment, particularly when the patient brings up material related to his early life, neither the patient nor the physician can or should prevent the development of an attachment and dependency—one that is more or less like that of a child to his parents. Eventually, however, if the relationship is to be helpful to the patient, he will have to emancipate himself from this attachment and dependence and learn how to stand on his own two feet. This, as any practising physician knows, is not an easy thing to accomplish; and, although during the early stages of treatment one may encourage attachment and dependence, it is well even at that time to keep in mind the eventual emancipation. The patient will have to be helped to "grow up" during the course of treatment, and one should encourage him to handle his problems on his own and not to depend too much on help from either the physician himself or other persons in the environment.

It is well to appreciate that there is a close interaction between the various stages of the patient's emotional relations to the physician and that which the physician experiences in regard to the patient. In fact, both the development of these processes and their eventual resolution are mutually interdependent. It is true that, for the patient to establish his childlike relation to the physician early in the treatment, the physician must not only express his interest in, and protectiveness toward, the patient, but he must actually feel them. As the treatment proceeds and the time comes

for the patient to emancipate himself and begin to lead an independent existence, the physician will have to give up the paternal role and permit the patient to decide things for himself. This is not a particularly easy task for either the patient or the physician, the situation being closely analogous to the relationship between parents and children.

We all know how difficult it is for most, if not all, children to give up their dependence upon their parents and strike out for themselves. Many times, this leads to the so-called "adolescent rebellion" against parental authority; and the relative degree of ease with which maturation takes place depends frequently upon the readiness of the parent to give up his hold on the child. It is not easy for either the parent or physician to relinquish the role of omnipotent protector, and the rebellion of the adolescent, or that of the improving patient, may be resented by either parent or physician. The wise therapist will realize the fact and, even if it occasionally causes some frustration, will encourage the patient in the process of breaking his attachment and will be ready to recognize the difference between resistance in the early stages of treatment, and the reaching out for independence in the later stages.

National Association for Mental Health, Inc.
10 Columbus Circle
New York 19, N. Y.

DEPRESSION

In the slave market of my melancholy mind
I mount the auction block
To sell myself to the highest bidder of misery

* * *

Against the bonds of servitude
I struggle, only that I might achieve
A bondage without reprieve

* * *

A permanent indenture is what I seek
That will insure
The master and myself

 "As joint owners
 Subject to the order of either
 (though commanded by none)
 The balance at the death of either
 To belong to the survivor
 (of whom there shall be none)."

JOSEPH ROBERT COWEN, M.D.

16 East Biddle Street
Baltimore 2, Md.

EDITORIAL COMMENT

OLE! IN THE HEAD!

Let's abolish football! And then boxing! Let the hurrahs and bravos and the roaring crowds cheer on other pastimes less sadistic and less cranioclastic!

Football cracks skulls. Cracked skulls go frequently with concussion and contusion of the brain, and these often end in mental disorder. Cracking skulls, however, is one of the most ancient amusements of the human race; popular legend will have it that clubbing the bride over the head was once preliminary to marriage. Football is a modern manifestation of this antique sport, one ardently defended in all its manifestations since "the memory of man runneth not to the contrary." Woe to any impious who lay irreverent hands on this modern version!

The last important effort to do away with football plunged its leader into a depth of obloquy unequalled since Cataline. Nicholas Murray Butler led what proved to be a pitiful crusade, motivated only in part by the matter of trauma recited here. True, there had been football casualties in 1905 or thereabouts, but the greater urgencies appeared to him to be a commercialization whereby undergraduate football team managers were leaving colleges with small (and legitimately acquired) fortunes, and the habit of other undergraduates (specifically his own) of rioting over the football field, with murder in mind, to the chant of, "To Hell, to Hell with Pennsylvania. . ." Too, he believed that college was designed for study, not for mayhem. Such, at least, is the folklore behind a noble experiment that put the experimenter—when the other football colleges failed to follow his lead—into an awesome depth of collegiate ostracism where insulting cartoons and lampoons, indignities in effigy, allegations of obscene habits, and a verse about a "blankety fool named Butler"* were the least of the amenities. Legend has it that when the great educator ran for vice-president on the William Howard Taft ticket in 1912, all of his students who had reached 21 voted for the ill-fated Republican pair in the forlorn hope of getting him off their campus.

*Much-sung, but for only too obvious reasons never-published, verse of *Columbia's* YMCA.

Nevertheless, let's abolish football, and now—and prepare for the storm of sour aspersions, rotten eggs, obscenities, dead skunks, and remarks about lack of masculinity that will ensue. If there is anything left afterward to storm at, the upholders of the prize fight can join in the storming.

Of course, he who would deprive mankind of the crack over the head is not only seeking to abolish an age-old game, but is also attacking man's folklore and trampling on his sense of humor. Perhaps the two were intertwined in the first place. Hephaestus, splitting the aching head of Zeu with an ax to release the full-blown goddess of wisdom, must have smiled grimly as he attacked the father who had lamed him. Maggie, pounding wisdom into Jiggs with a rolling pin, is a modern paradigm of infantile, sadistic amusement.

Flints which could have been, and probably were, mace heads, appear among the first artifacts of paleolithic man. Head-smashing and implements for head-smashing appear among the oldest records of western civilization. The great king "Nar-mer" strides into history to regulate irrigation by the overflowing waters of the Nile, and records the event on a sculptured mace head, his symbol of authority. Heracles roared through Greek mythology, carrying a cranium-cracking club; he still bears it as he marches nightly around the pole in the chill northern sky. And, if the Minoan double-ax was a weapon, its function was surely head-breaking.

The sling and the sling stone formed a weapon against the head. Prehistoric man left sling stones behind him. The Assyrians used them. In Israel, when the rest of the people went out to fight Benjamin, 700 left-handed Benjamite slingers were among the picked troops that opposed them; and David slew Goliath with a sling stone that "sunk into his forehead."* Balearic slingers marched against Rome with Hannibal and for Rome with Caesar. Bone-breaking weapons went the length and breadth of the Roman empire with the legions and were part—the sling presumably excepted—of gladiatorial *armamentaria* from the hot sands of Syria to the great wall across the cold lands of the Picts.

Rome fell to horse-riding peoples who, among other weapons, swung the mace. The armored medieval horseman carried a mace at his saddlebow. In a colorful example, when the man of god

*Judges 20, 16, I Samuel 17, 49.

went forth to medieval war, he was forbidden to shed blood. But he could break bones, including head bones. The bishop on the battlefield, therefore, carried a mace; in some sets of representational chessmen, the bishop still carries one. The modern mace is, of course, shrapnel. Because of it, Scots bonnets, caps and campaign hats have been doffed for the resumption of steel head-pieces.

European man has not been alone in his predilection for breaking people's skulls. When North American Indians honored a brave prisoner by making him run the gantlet, he was forced to dash between two lines of warriors with clubs upraised to bash his brains out. The fighting Iroquois aimed their war hatchets at the head, and carried, besides, lethal little clubs that the French significantly named *casse-têtes*.

Then, too, upon a time, in the great "land of the four directions," Tawantin-suyu, there rose empire after empire, based on a proficiency in skull-fracturing that has never been surpassed. Since the "rememberers" are long since dead and their *quipus* silent, we do not even know where arose (or what they called themselves) the peoples we designate as Nasca, Chimú, Chavín, Mochica and Quechua; but we do know their fondness for the sling and the mace and the deadliness with which they wielded them. One can see, depicted on a Mochica vase of around 12 centuries ago, one soldier smashing another soldier's head in. And there is evidence over a span of two millennia of astonishing surgery performed by the people of the Andes in repair and alleviation of these head wounds.

The smashing of heads and the addling of brains as the national sport of the Inca and their predecessors was terminated summarily by Francisco Pizarro in 1532 (the surviving Inca were quick to adopt Spanish firearms and other weapons, with which they successfully resisted for 35 years). But for 2,000 years before, the Andean armies had advanced to battle with a hail of deadly sling stones, followed by a charge with the fearful mace, the *macana*, a weapon with a rounded or star-shaped head, in later days cast in bronze, in earlier times, cut from heavy stone.

The people of the Andes learned to cope with the fearful resulting traumata when eternal Rome was still vassal to the Etruscan Tarquins. The Peruvians recognized the relationship between stupor, delirium, and other effects of increased intracranial pres-

sure, and skull fracture; and they proceeded to relieve the pressure by highly skillful trepanning. (An educated guess, as is frequently noted, is that they may also have trepanned for mental symptoms other than those caused by trauma, letting out the devils through the holes, in the world's first psychosurgery.) Whatever the rationale—and there are no *quipus* from 500 B.C. and no “rememberers” to interpret the knotted strings if there were—the prehistoric surgeons did a notable job of it.

In remote times, they cut into the skull with obsidian; in the days of the Inca empire, they used the fearsome-looking *tumi*, a bronze knife that resembled a kitchen chopping knife of the sort one uses for making coleslaw. A contemporary authority on ethnogeographical exploration of the Inca region summarizes the archeological conclusions.* Medicine and surgery of the ancient South Americans were, he thinks, about as advanced as they were in Europe in the days of Ambroise Paré. The Peruvians had scalpels, pincers, needles for suturing, besides their trepanning knives; modern surgeons have actually performed successful trepanning with the ancient instruments. The ancient practitioners used the tourniquet (applied around the head for skull operations); they had cloth resembling gauze, and used cotton swabs; there is speculation that they used local, if not general, anesthesia—effective narcotics were at least available and in wide use for nonmedical purposes.

Despite stout shields and helmets of wood and plaited cane, the empire of the Inca must have had a punch-drunk male population. More than 10,000 trepanned skulls have been found in Peruvian graves, with, says our authority,** “An enormous number . . . with the bone tissue renewed, showing the success of the operation.” But the pre-Columbian repairmen of the central nervous system were no Harvey Cushings. Headaches and amnesias must have been the ordinary sequelae of a battle; and the Incaic countryside must have been full of intellectually-impaired specimens with symptoms ranging from Jacksonian and grand mal epilepsy through personality disorders to profound mental deterioration.

One could argue that both the rationale and the emotional needs that are involved in swinging maces for conquest and in a

*Von Hagen, Victor W.: *Realm of the Incas*. Mentor Book. New American Library of World Literature. New York, 1957.

**Von Hagen, Victor W.: *Op. cit.*

modern football game are too various for legitimate comparison. The unconscious motivation of naked aggression is, however, plain in both; and football, besides, is the spiritual, if not physical, descendant of the brutalizing gladiatorial combats of ancient Rome. So, of course, is boxing, which—as already remarked—our civilization would also do well to get along without.

The case for football should be presented, if one is to evaluate the case against it. There is no doubt at all that football is a great and socially-accepted emotional outlet for aggression for millions of persons. It should be remarked that so were gladiatorial combats, which were socially accepted also in their setting and in their day. And so is warfare, which is still socially, though not ethically or intellectually, accepted in our own setting in our own day. Football is a better outlet for sadism than sharpened swords or nuclear reaction. It is also a comparatively harmless outlet for xenophobia. There is less material and spiritual damage in the chorused allegation that far above Cayuga's waters is an "awful smell, . . . we say it's Cornell," than in anti-Semitism or in lynching a man with a different skin color. The difficulty is that jeering at a rival college has never been demonstrated to prevent less desirable outbursts.

Yet for the spectator, football, with its yelling crowds and wild excitement, is a release of tension—sadistic, no doubt, if one's team wins, masochistic if it loses. There is also the exciting element of chance in football; a lucky pass or a fumble can bring as dramatic a turn as can be found in any entertainment. And there is, for the spectator at least, an intellectual component, in trying to outguess and then second-guess the quarterback. For this, it can be remarked, one can get better intellectual exercise of precisely the same kind in chess; and fewer heads and necks are broken.

If there is a trace of ambivalence in this discussion, it is because of an uneasy feeling—due in part to the normal human component of aggression, no doubt—that some of the alleged good points of football are good points in actuality. From time immemorial, the crowd, the mob, or the populace has found it necessary to release aggression, for instance; and football, as already remarked, is a comparatively harmless way of releasing it. It compares very favorably indeed with bellowing "*Ole!*" after the "moment of truth," with cheering while Christians are thrown to the lions, or

while witches are burned at the stake, or traitors hanged, drawn and quartered. A good many social and psychological scientists believe that this sort of emotional release is necessary and that society must find harmless, if not constructive, ways of obtaining it.

The defenders of football, and of sports in general, frequently describe them as harmless and socially-constructive activities. There is the ancient contention that sports train the participant in "manliness," whatever that is; in fair play; in keenness; in healthy competitiveness; in stoicism, endurance, courage and fortitude; in how to be a good loser; in short, in all the accomplishments a boy needs to grow into a masculine man. There is, for instance, the supposed remark of the Duke of Wellington that Waterloo was won on the playing fields of Eton. But Waterloo was won because, among other matters, Napoleon's cavalry—unsupported by the French foot—broke itself against the British infantry squares; and the Imperial Guard later suffered the same fate. But this was a matter of organization and tactics, not of Eton-molded characters; the losers were as brave men as the winners; but horsemen were no match for infantrymen in squares; and the Guard in its turn met the same sort of overwhelming infantry and artillery defense as did Pickett a half-century later. "Old Hooky" to the contrary, it is difficult to see what the playing fields had to do with it. The enlisted men of the Inniskillings, "lying literally dead in square," were not Etonians, whatever some of their officers may have been. Most of the 40,000 or so British troops which formed the core of Wellington's allied army never saw a playing field other than the village green.

But if competitive sports do not harden one for war, what are they good for? They do not promote physical health any better than calisthenics or gymnastics; a walk or a trot for the fun of it provides as good exercise as a foot race; and one can benefit physically from non-competitive, as much as from competitive, swimming.

Competitive sports develop sportsmanship, they say; one learns to play according to the rules, learns what is and what isn't "done." For example, the Englishman, riding to hounds after the fox, shouts, "Tallyho!" not, "There goes the blankety blank!" The competitor in sports learn to give the other fellow a break; he learns to win gracefully and to lose happily, having in mind

that at the last, "the One Great Scorer . . . marks—not that you won or lost—but how you played the game."* That is all very well and presents an ideal that is supremely good for boys until somebody bashes their teeth in, or until they discover, maybe in bayonet school, something the professional sportsman has known all along, that there is nothing like a kick in the testicles to "discourage" an opponent. Leo Durocher, who ought to know, is often quoted to the effect that "nice guys don't win."

If games were played strictly according to the spirit and the rules! But they are not; and one doubts if they ever have been. For modern practice, the doubter may be referred to that great authority, Stephen Potter, author of a standard text on the subject,** with illustrations from British sports which are just as applicable to American, with appropriate twisting of sport terms. Anglo-American sports practice is the world's standard, as any doubter can verify by looking up sports vocabularies in French, Latin-American Spanish, or, so one understands, even in Japanese.

If Anglo-American practice is standard, Mr. Potter's problem of how to win without actually cheating is very important indeed. One says the wrong thing at the right time to jar an opponent; one delays an opponent until he has a case of nerves; one distracts his attention from the play; one offers unneeded and irritating advice and assistance. Golf, tennis, badminton, bridge, poker and chess are some of the pastimes treated in Potter's manual. The uninstructed reader soon has an uneasy feeling—then one of *déjà vu*. He has been playing, not against sportsmen, but against gamesmen, for years without suspecting it. And the chances are that he is also a bit of a gamesman himself. For gamesmanship is the way the game is played.

Consider a player of all-American ability on an otherwise less than adequate football team. Does the opposing team congratulate itself happily on the chance to play against such a distinguished fellow—and try to counter his superb quarterbacking, his passing, his running, his line-plunging? No, the opposing team does not. The opposing team sets to work to put Mr. Triplethreat out of the game. It would be very easy to cite many instances where such a player regularly kept his mediocre team ahead of much

*Rice, Grantland: *Alumnus Football*.

**Potter, Stephen: *The Theory and Practice of Gamesmanship or the Art of Winning Games Without Actually Cheating*. Holt, New York, 1948.

stronger combinations for the first half or the first three quarters, only to be overwhelmed when the tiring star proved unable to play longer practically single-handed against 11 men. In an actual instance, he was lucky to go through the game without being knocked unconscious and luckier when he managed to go through the season without a cracked skull or a few broken limbs. Sportsmanship? No! Just the finest kind of gamesmanship!

Football extends a perennial invitation to gamesmanship. The penalties are so framed as not to discourage infractions but to discourage getting caught; some (that for delaying the game, for instance) may be deliberately incurred for advantage in the closing seconds of the half or the fourth quarter. The college eligibility rules are framed for evasion; witness the fate of nearly the whole West Point team a few years ago, when the members seem to have believed in all innocence that the faculty expected them to cheat in examinations. Recruiting has been, and still is generally, a crude performance, carried on with all the ethical principles of hiring goons as strikebreakers; the star player goes to the highest bidder, with all but a guarantee that he will be helped through his college courses to his bachelor's degree, regardless of intellectual proficiency. Consider what happened to the "ivy league" colleges when they resurrected their ethics and stopped "buying players." Everybody else has been beating them ever since.

Recall, too, the slick trick of the famous Carlisle Indians half a century ago. They trotted out on the field with leather ovals sewed over the upper left quadrants of their jerseys. When Carlisle went into motion, 11 men appeared to be running with 11 footballs; and the opposing team was forced into a guessing game, not a contest of skills. But why not? There was—until hasty action was taken—nothing in the rules against it. And Potter, incidentally, gives an illustrated discussion of clothesmanship, showing how pre-game preparation by wearing the right, or the wrong, clothes can rattle an opponent of superior skill into losing almost anything. Wilson's sketch for Potter's book of "the wrong clothes in which Miss E. Watson beat Mrs. de Greim in the Finals of the Waterloo Croquet Tourney, 18th August 1902" is a flawless gem of the ludicrous. Anybody who thinks it too ludicrous might simply recall the effect of Gussie Moran's remarkable lace panties on the tennis court!

These examples are all by way of hasty illustration of the fact that there is more gamesmanship than sportsmanship in modern sports, and that gamesmanship is not sport at all but is psychological warfare. It involves misrepresentation, misdirection, sadism, threatening, lying, bullying and cheating. It is the contention here that it always has involved such things and probably always will, since these are human, if reprehensible, characteristics, and sports are played by human beings. But some sports seem designed to bring out and to foster more good qualities than bad; some, and football and boxing are not the only ones, more bad than good. The situation is covered graphically and adequately by John Farina, professor of social work at the University of Toronto and a gentleman who knows what he is talking about. He was formerly football coach at the University of British Columbia and has been a professional official of Canada's Western Interprovincial Football Union.

About a year and a half ago, Professor Farina addressed a Better Leadership Institute of the Boys Clubs of Canada. He told the institute, "All sports breed cheating, larceny, fighting and downright sadism. Aside from the possible development of skills of questionable use and perhaps physical development, there is very little use in sport or recreation activities in themselves.* This is an indictment of sports in general; he does not single out football. Rather, to bring the matter home to Canada, he does single out hockey as "the most degenerate sport in the world," a piece of nonchalant *lèse majesté* comparable to yipping in circles in front of Buckingham Palace and barking at the Queen.

"I am," says Professor Farina, "... a lover of sports. ... I recognize the potential for good in sports activities; but also I am terribly disturbed about what is happening to sports generally. ...

"I will leave it to the sports journalists to identify specific examples (or perhaps the promoters would like to do this), of the unfortunate fruits of modern-day sports: the pugilist who is 'punchy' and condemned to a life of semiconscious oblivion; the hockey player whose self-esteem and recognition are based on the number of stitches he acquired as a devotee of Canada's most popular sport; the wrestler who is an outright cheat and fake (is there another kind?) and whose status in the sports fraternity

*Farina, John (Quoted in, and contributor to, discussion): Canadian sports: degenerate or uplifting? Toronto Star Weekly Magazine, December 21, 1957.

is based on a complete disregard of the rules; the tennis player who sets a price for his appearance in an amateur tournament; the golfer who is so confused as to the examples he is supposedly exemplifying that he has difficulty getting himself classified as either an amateur or a professional; the former professionals who blandly and apparently without conscience take the Olympic oath; . . ." That seems to be that; and there—except for some psychiatric and other medical considerations—you have it. Farina thinks that whether we get "positive or negative values from sports depends upon the quality of leadership," and his attack on sports is in the course of a plea for responsible leadership, a plea which does not appear to be exactly overconfident, but one in which he believes he will have support. (And here is some of it.)

The medical considerations which weigh against football are monumental, but for the most part, must be assessed without statistics. Available records of deaths and injuries are incomplete, unofficial compilations by news associations and sports organizations or sometimes by educational authorities. They are not in any sense reliable medical or legal records. A football injury is not a legally reportable disease, a news writer compiler may never hear of it. A death following such injury months later may never be noticed by the news writers at all. About all that can be said for what figures there are, is that they probably show a much less serious situation than actually exists. It would probably be a practical impossibility, in terms of sufficient time, sufficient investigators and sufficient money, to compile complete and accurate records from the official mortality and morbidity statistics which are scattered in local record offices all over the country. What medical people can testify to is, thus, based not on statistics, but on general information and specific clinical observation. General information is to the effect that there are deaths annually from skulls fractured and necks broken on the football field. Clinical observation verifies numbers of these deaths and numbers of injuries. The doctor can testify to instances of damaged eyesight, crippled limbs, impaired hearts and otherwise damaged internal organs. There may be competent and prompt medical attention at the time of the game; and a boy, operated on almost immediately for a damaged kidney, may still die of the sequelae years afterward. Broken arms and legs and injured spinal columns are common; so are knocked-out teeth and squashed noses; and

orchiectomies appear to be occasional necessities, despite metal protectors. The psychiatrist and the neurologist may well believe that neurological injuries with psychiatric sequelae are the commonest of all. Somebody is knocked unconscious in almost every hard-fought game, testimony to at least minor, reversible brain injury. The national annual total of discoverable brain injuries that are not minor and not reversible would be an important medical statistic; and making an effort to find it—despite the difficulties noted—might be well worth a research effort by a psychiatric or neurological association.

To physical injury, must be added plainly visible psychological injury—emotional retardation. The college and professional football player (and to varying extents the professional player and the "professional amateur" of most other sports) lives in a world that never quite grows up. He is fixated in the adolescent, homosexual stage. This is not perversion homosexuality, of course, but represents an early stage which the normal person goes through in the normal course of development. For boys, it is the stage where "the crowd," the team, and the gang are everything. Boys' activities from baseball to school carpentry fill the whole of life; girls simply don't exist. A career in amateur or professional sports prolongs this adolescent stage unnaturally and to the detriment of adult social, familial and personal relationships.

The athlete would scorn to admit it, but the paradigm of this early adolescent arrest in development is Peter Pan, the boy who never grows up. In professional sports, Babe Ruth is the perfect example. Among college football heroes, the name of the boy who never grows up is legion. So it is among the enlisted, and some of the commissioned, personnel of professional military establishments. So it is, in particular, among professional boxers. It is much as if girls organized clubs for playing with dolls and continued to invest their principal interest in dolls even when they became grandmothers.

The situation is emotionally unhealthy; the wife of the emotionally-adolescent athlete is a small boy's wife, even when she reaches old age. She is never allowed to be a full, adult participant in a grown-up world. Except in a few games like bowling, tennis and golf, and usually only in amateur play in these, she cannot join men in athletic contests. And even in these games, there is more segregation of the sexes than mingling; tennis, for instance,

provides a suitable environment for the person fixated at the adolescent level; it also once provided a suitable environment for a famous champion who was a perversion homosexual. One should not misunderstand, and so conclude that this view leaves no place for women in the athlete's life. They have a definite place, but it is not that of adult equals. They fill the role of the small boy's admiring mother and little sister and of his worshipful high school girlfriend. On a different but still adolescent plane, they are something to exhibit, dance with, sleep with. They are even something to marry if that is the only way one can get them; but they are not something with which one plans mature partnerships in the business of living.

There are other sociosexual implications of the overemphasis on competitive sports. Football and other strenuous games are still prescribed as a "remedy" against masturbation. Recall the youth leader in *Elmer Gantry* who advised the college students to "get out and run like Hell." A good many psychiatrists would be doubtful whether arrested development at the homosexual level is much of an improvement over autoerotism. The "remedy" for both, of course, is to grow up emotionally.

For some athletes (recall the tennis champion), women play no part at all. Fixation at the adolescent stage is replaced by perversion homosexuality. In team-competitive sports the conditions of group living, playing, training, undressing, showering, are all calculated, at the least, to feed homosexual interest. With all the benefits that sports are supposed to bring, there has always been a high incidence of homosexuality in cultures devoted to sports, as in cultures devoted to war—or to religion. The Norse, the Nazis and the ancient Greeks are examples. In predisposing circumstances, it is an easy step from autoerotism that is almost universal to mutual masturbation, and so to "standard" perversions, in young susceptible persons. And one might remember that the famous "fag" system of the British public schools (*Tom Brown's Schooldays*), which was supposed to develop manliness, discipline and hardihood in athletics, had its homosexual implications; "faggot" is now a derogatory term for a male homosexual; and it is hard to believe this is coincidence. As a final comment on homosexuality in the atmosphere of sports, one might recall the tale that would attribute the origin of anti-Semitism to the

ancient Olympic games, when the Jews offended the Greek athletes by criticizing their flagrant practice of sexual perversions.

This leaves the case against football, based on deaths and on somatic and psychological injuries that cannot be totaled, to be weighed against intangible and supposedly good effects that cannot be totaled either. Football as a spectator sport is without rival; and certainly some of its effects on the spectators are not baneful. They may, in fact, be beneficial psychologically or emotionally, as any alumni association will maintain. But even if wholly beneficial, are they worth half a hundred lives every football season, or even worth a hundred addled brains or twisted bodies? This is without consideration of occasional spectator deaths from overexcitement, or of many more than occasional aftergame deaths in the traffic accidents that follow overcelebration.

But if the scores for and against football cannot be totaled, the case is clear against professional boxing. The manly art is the illegitimate descendant of a crude form of gladiatorial contest. In this, ribs and skull were matched against a weapon which was more brass knuckle than boxing glove, a fearful creation of leather straps and metal, fouled with blood and brains, and known as the cestus. A blow with the cestus could smash a man's ribs into his chest cavity and stop his heart, or could pulp his face, or could scramble his brains within his shattered brain case. The custom is ancient. Homer's heroes engaged in cestus bouts which must have been almost as fierce as the actual combat "Far on the ringing plains of windy Troy."

There have been improvements. It was a definite step toward a more humane contest when the hard binding was abandoned and the bare fist—soaked in brine, withal—replaced the cestus. The change seems to have taken considerable time, by the way, for the cestus, inherited by Rome from the Olympic games, disappeared only with the fall of Rome and the abandonment of civilized Roman customs. When boxing reappeared more than a thousand years later, bare knuckles were in vogue. With bare knuckles, a rib might be cracked without crushing the whole chest; or teeth might be knocked out or a nose broken, or a pre-Potter gamesman might "accidentally" gouge an opponent's eye out with his thumb, or a man might be knocked unconscious, all without making permanent goulash of the face.

There is some doubt, and it has been expressed by respectable and informed medical people, whether boxing has become any safer since the bare-knuckle era. When gloves were first worn, it was for protection of the fighters' hands. If the gloves were not cestus-hard, they were far from cushions. Later, every step toward glove padding, and then to more and more padding, was taken with the aim of softening the blow for the recipient. The idea was that the softer the blow, the more humane, though this was not always the motivation—men hit with padded gloves stood up longer and so gave longer entertainment for the spectators. Today's fighting gloves, while softer than brass knuckles, are by no means pillows, a term reserved derisively for the fat mittens used for training exercises. It is now doubted that several hard blows with bare knuckles can do as much damage as repeated flurries of lighter blows delivered with gloved fists. Boxers continue to be killed in fights with gloves, as they used to be in fights with bare fists; and there is an appalling amount of punch-drunkness, though data for comparison with pre-glove days is meager.

Better than it used to be or not, boxing continues to be a nastily sadistic sport, brutalizing spectators and participants, thriving on crooked deals, fixed fights and foul play, and providing support for, among others, disreputables who, at the best, are lawbreaking toughs, and at the worst are a murderous lot of gamblers and racketeers. Sure, there have been and are boxers, managers and promoters who are fine men and good citizens; they represent the ideal—the ideal of what boxing is supposed to be but isn't—and anybody at all can name a goodly list of them. But their good deeds shine faintly indeed in the naughty boxing world; prize fighting is, in general, a sordid tale of exploitation, entertainment of a contemptible sort bought at a high price in misery and injury. This discussion is concerned with medical and psychological, not moral, questions; and its consideration of the price of boxing will be only of that part of the price that is paid in the coin of medicine, somatic and psychologic damage.

The psychological effects of boxing—its sequelae in personal and social mental health—deserve closer examination than is usually given. In both traditional speech and the language of the sports pages, there is considerable glorification of prize fighting. Boxing is "the manly art of self-defense"; it develops the muscles, the wind, the fighting heart, the spirit of never-say-die. It is the

sport above all sports at which the truly manly youth should excell. The ideal boxer of legend is a superman, strong, brave, honest, clean-living, chivalrous, courageous, dedicated to fair play and to fight to the bitter end whatever the odds. He is an unpolished Sir Galahad, and any clean-living boy can be like him if he has guts enough. The Eagle Scout has the same ideals; the difference between the Eagle Scout and the fight champion is skill at fisticuffs.

Today's cynical and sadistic fight fan is better informed, though he does not go out of his way to share his information where it may dull youthful enthusiasm. He is likely, in fact, to talk of boxing as a fine, clean, honest game, in which rewards go unfailingly to the most skilled and most courageous. But even the most simple listener must wonder sometimes. Why, for instance, does the referee have to keep warning the champ, round after round, to quit hitting below the belt? Why do both fighters disregard the rule against hitting in the clinches, trying instead to hold the opponent with one hand and cripple him with the other? Can the aim of boxing possibly be to break all the rules you can get away with? The aim of boxing, in fact, can be and is. It always was.

The great bare-knuckle fighters of English tradition fought foul. In the early days of the modern ring—perhaps 200 years ago—a fighter aimed to wrestle his man down in a clinch, then trip and fall heavily on him, injuring him if possible. If this was done purposely, it was a foul, so it was regularly done “accidentally.” It was an approved and recognized way to win a bout. Fighting foul was the expected and general practice; a fighter fought the rules as well as his opponent; and if he was not caught, no real sportsman thought the worse of him. Referees were liberal, too, in interpreting the rules. In 1795, a bruiser named “Gentleman” Jackson fought Dan Mendoza for the championship of England. He grabbed Mendoza by his long hair with one hand, and holding him helpless, pounded him to pulp with the other. The referee adjudged this fair; and boxers have cut their hair short ever since. But in the middle of the twentieth century there are still prize fight enthusiasts who grow vastly indignant about it as one of the foulest tricks of all time. John Dickson Carr takes time for a digression in the middle of a “historical” mystery

story.* "They ruled it no foul," says Carr, "though some of us still holds it was the dirtiest of fouls."

This was the actual pattern beneath the mythology that was told and retold for two centuries for the emulation of British and American youth. The prize fighter was always an admirable character and a great man. If one found out what he actually did, instead of what he was supposed to do, he still remained an admirable character and a great man; the admirer simply accepted calloused, cynical and brutal behavior as the norm—to replace the vanished vision of a Sir Launfal of the prize ring. If John L. Sullivan swiped bananas from Boston fruit stands, he had a right to, and the owner should have felt honored; if Jack Johnson paraded nauseating sex orgies, he was world champion, wasn't he?

It is difficult for the psychiatrist to condone the fostering of such standards of conduct. The process builds up and defends the anti-social attitude that success in life justifies any foulness one can get away with. It is conducive to criminosis and neurosis. Admittedly, some pretty decent specimens have gone into the prize ring and come out of the prize ring unscathed; but the general effect has been deleterious. The second-raters among the British bruisers of George IV's day were for anybody's hire who wanted an enemy beaten, crippled or killed; and one can recruit plenty of bullies today among prize ring hangers-on.

These are general allegations with a few examples—and are to be referred to social and individual psychiatry. One can be more specific in reference to neuropathology and its psychiatric sequelae. A century ago, a kick from a horse was a common passport to the insane asylum. If a fighter's punch is somewhat less frequent as a hospital admission ticket today, it is only because few fighters have the strength of muscle that one finds in the hind legs of a horse. However, the possibility of mind-crippling injury is there; and the occurrence is an unpleasantly commonplace reality. Most members of this QUARTERLY's editorial board have had the privilege of knowing one or two well-known boxers who became deplorably punch-drunk and spent their last days as mental patients. The condition, of course, is as old as the game.

Let us consult the *Encyclopaedia Britannica*.** Lucilius writing of a Greek boxer of Etruria (*Anthologia epigrammatum graeco-*

*Carr, John Dickson: *The Bride of Newgate*. Harper, New York, 1950.

**Article on pugilism, *Encyclopaedia Britannica* (eleventh edition).

rum) says, 'Aulus, the pugilist, consecrates to the God of Pisa all the bones of his cranium, gathering up one by one. Let him but return alive from the Nemean Games, O mighty Jupiter, and he will also offer thee, without doubt, the vertebrae of his neck, which is all he has left!' Nevertheless, the *Britannica* remarks: "The rules of Greek boxing were strict. No wrestling grappling, kicking nor biting were allowed . . . it was strictly forbidden to kill an adversary on pain of losing the prize."

The problem has been recognized by modern medical men for years back; one member of this journal's editorial board had the opportunity once to plan a service for professional boxers which was to have provided regular psychiatric and neurological examinations—with electro-encephalograms repeated at regular intervals. Ethically should physicians condone this sport by so serving it? A British report of something more than a year ago showed tracings indicating brain injury in a majority of the electro-encephalograms of 69 former boxers. In the light of this and other data, the world famous medical journal, *The Lancet*,* is urging British physicians to fight for the abolition of boxing in their country.

"Sixty-four deaths, including twenty-two amateurs, in four years," says *The Lancet*, "is a prohibitive price to pay for a sport which makes the brain and its exquisitely sensitive extensions such as the eye legitimate—in fact, main—targets.

"If boxing causes fatal cerebral damage in a few contestants, the natural conclusion is that it causes material brain injury in many more." The journal goes on to urge that doctors warn boxers, school heads, parents and leaders of boys' clubs of the danger of delayed brain injury from boxing. *The Lancet* is also disturbed over the televising of boxing matches, a matter concerning which American medical people can sympathize. It brings to mind the somewhat irrelevant report of a colleague that he is called "not infrequently" to see a patient who has had his first anginal symptoms while watching a televised prize fight. This one physician's experience must be multiplied by many thousands.

Surely, there should be some better way than prize fighting or watching prize fights to release sadism, or discharge aggression, or however else one's particular school of psychiatric theory wants to phrase the thing. This discussion is not only an effort to urge

**Lancet*: Editorial, June 5, 1959.

that we try to find such a better way, but it aims to extend a little overseas encouragement to *The Lancet*, and to add its vote to a total that one hopes will become unanimous.

Perhaps injuries in sports other than boxing and football should be dealt with briefly. The regular player of basketball, hockey or soccer (association football) is lucky to come out of a season with a whole skin and whole limbs. Almost any other competitive sport can produce its quota of injuries. In baseball, a runner can be crippled by spikes, or a batter killed by a ball—only a few years ago, in fact, a number were killed by the now-outlawed "bean ball." The toll of all the other sports added together, however, cannot equal the record of deaths and injuries in boxing and football.

To attack either boxing or football, is to attack large vested financial interests; the enormous gate receipts in boxing are well known; and the colleges and universities whose students are killed and injured in football lean heavily on the sport financially—directly in some cases, indirectly in many more, through stimulating the interest and enthusiasm of wealthy benefactors. The nation's emotional investment in football is probably the heaviest in any sport, baseball possibly but no means certainly excepted. And there is a good-sized emotional investment in boxing. The British once elected a prize fighter to Parliament; and the Americans once sent one to Congress. A great prize fighter is, of course, a national hero, like a great general; and a democracy's proper reward for a national hero is elective office. But when one considers the power of what is attacked, it should be remembered that there were huge financial and emotional investments also in the Roman amphitheater where gladiators fought to the death—and under the successors of Rome, audience taste changed.

In the United States, there were once huge financial and emotional interests involved in the old-fashioned fireworks and cannon-cracker celebrations of the Fourth of July, celebrations that have been outlawed in most states just the same. It was a pity to see the noisy and glittering old-fashioned Fourth go; but it wasn't worth its horrifying annual cost in deaths and injuries. Similarly, it would be a pity to see boxing go, with its ancient traditions of courage and fair play (however horribly betrayed in practice). And it would be an even greater pity to see football go—a game that is fun to watch and fun to play. Football is

also more than a game; it is an occasion for songs and cheers, parades and color. It is swift, spectacular and thrilling; and, it was remarked at the start of this discussion, it provides hundreds of targets for the harmless outlet of aggression. Undergraduate, alumnus, and Old John Public (particularly with the institution of the professional game) all get fun and thrills out of football. It would be more than human control of emotions not to feel at least ambivalent about abolishing it. But it ought to be abolished.

Neither boxing nor football is worth its cost.

That something is not worth its cost, is a purely intellectual argument. The psychiatrist of all people is well aware of the ineffectuality of intellectual argument where there is strong emotional investment; or, to put the matter in more general terms, logic is not impressive to people who think with their feelings. When football is in question, most people do seem to think with their feelings. Nicholas Murray Butler's undergraduates of yesterday and the cheering grandstands of today represent thinking with feelings. Today's football enthusiasts represent many professions and occupations other than medicine. And the boys who once pilloried Butler were neither neurologists nor psychiatrists. Those who became so later may possibly have changed their opinions.

With all this, there is a sound psychoanalytic tenet that the voice of the intellect, though soft, will yet win a hearing. The voice of the intellect, in fact, has prevailed in the past in such instances as the abandonment of the old-fashioned barbarities of the Fourth of July. It can prevail against boxing if psychiatrists and neurologists who know boxing's costs in tragedy will join to raise the banner of reason against it. Admittedly, better statistics and more study would be welcome in the instance of football. But the evidence already compiled against it is overwhelming. It is more than strong enough to justify action now. Our culture must surely have passed the point where we need to maim mentally and to kill—to make fiesta.

LETTER TO THE EDITOR

BRITISH MENTAL HEALTH PROGRESS RAPID

To The Editor of THE PSYCHIATRIC QUARTERLY:

Sir:

An article by Dr. Anthony Hordern in your issue of April 1958, on "British Psychiatry Today," was a very balanced report and can only deserve praise. However, the Mental Health Services in Great Britain have developed in recent months so rapidly that it can be fully understood if Dr. Hordern is not completely up to date. He is probably not aware of the importance of the movement away from institutional treatment.

One of the major developments, "The Day Hospital," is not mentioned by him. Until very recently there were 42 day hospitals open in Great Britain, and new ones are being opened all the time. Further, new experiments with night hospitals, therapeutic community hospitals and self-governed organization of patients are showing promising results. All these experiments have proved that mental patients can be treated outside mental hospitals.

The new Mental Health Act, which is passing through the Houses of Parliament just now, which Dr. Hordern could not report on as yet, is likely to inspire still further greater changes.

Joshua Bierer, Medical Director
Marlborough Day Hospital
38 Marlborough Place
St. John's Wood
London, N. W. 8.

BOOK REVIEWS

The Integration of Behavior. By THOMAS M. FRENCH, M.D. Volume I. Basic Postulates. ix and 272 pages. Volume II. The Integrative Process in Dreams. xi and 367 pages. Volume III. The Reintegrative Process in a Psychoanalytic Treatment. xii and 484 pages. With indices, bibliographies and appendices. Cloth. University of Chicago Press. Chicago. 1952, 1954, 1958. Price: Volume I, \$5.00; Volume II, \$6.50; Volume III, \$10.00.

Theories of the drives have been modified repeatedly, from the beginning up to recent years, by Freud himself and other analysts. Still, all explanations force us to search back to the same repressed conflicts, deriving from childhood experiences, if we are to succeed in interpreting the neuroses. Since the underlying factors are similar in all cases—weaning, toilet-training problems, sibling rivalry, the Oedipus complex and so on—why do different persons display different kinds of neuroses? In dealing with this problem of “choice of neurosis,” in clinical therapeutic work, there are many aspects besides these common repressed conflicts, and yet the individual patient’s behavior remains unexplained by his own particular circumstances. To solve this problem, French starts his study with John Stuart Mill’s “joint method of agreement and difference,” and calls it “analysis by comparison.”

French assumes that a person’s behavior is determined by two factors: “1. A relatively permanent constellation of reaction patterns, which is called his personality. 2. The situation to which he is reacting at a particular time.” It is assumed that rational behavior, neurosis and dreams can be analyzed into components that are in part common to the three, and one must seek to discover what these common factors are; thus his working hypothesis is that, since behavior, dreams and neurosis have so much in common, one can find, in irrational behavior, fragments of the integrative ego which must be postulated to account for rational behavior. “By comparing neurosis with rational behavior, we shall also study the effects of conflict on behavior, and by bringing dreams into the comparison, we shall inquire into the effect of sleep. Carrying the analysis further, as already indicated, we shall try to discover the effect on a patient’s dreams of differences in the precipitating circumstances and of events that have occurred in the intervals between the dreams.” Thus, French has a highly specialized approach to the study of behavior and a strictly empirical method for reconstructing the pattern of a patient’s personality.

In dreams, (Volume II) French mainly follows Freud’s classical work, dealing systematically with the organization of the dream thoughts—

an organization which is related to cognitive structures. He discusses what can be learned about the dreamer's personality structure by comparing dreams dreamed at different times and under particular circumstances (analysis by comparison).

In his third volume, French describes the treatment methods through which integration is achieved, and it is assumed that the aim of therapy must be to restore the patterns of rational purposeful behavior.

Each volume may be read as a unit, each deals with fundamentals. They require a close skillful and serious reading. The writing is neither routine textbook material, nor partisan pleading. The aim is to build an ego psychology on the basis of fundamental principles. There are to be two more volumes. When the set is completed, it will be a monumental contribution to the psychological and social sciences in general, as well as to ego psychology in particular.

Virginity. Pre-Nuptial Rites and Rituals. By OTTOKAR NEMECEK. 129 pages. Cloth. Philosophical Library. New York. 1958. Price \$4.75.

Virginity is a popular publication, surveying ancient and modern beliefs and customs on a worldwide scale. It is reasonably comprehensive; it is well presented and it is apparently authoritative. The publishers note that the scientific references on which it is based appeared in a work in German published in Vienna. The armchair anthropologist will not find much that is new in this volume, but will find much familiar material brought together from numerous sources and well organized. The author seems informed psychologically but also seems to place more emphasis on social and economic factors than many other students would consider justified. His book can be recommended as good introductory reading, but it seems overpriced.

Alcoholism, Basic Aspects and Treatment. HAROLD E. HIMWICH, editor. 220 pages. Cloth. The American Association for the Advancement of Science. Washington, D.C. 1957. Price \$5.75.

In December 1955, the American Psychiatric Association, the American Physiological Society, and the American Association for the Advancement of Science held a two-day symposium on basic aspects and treatment of alcoholism. This readable and well-balanced monograph is a compendium of papers presented at this conference.

The book's first section has eight articles on some of the metabolic, neurologic, and physiologic aspects of alcohol in lower animals and in the human. Grenell opens with a stimulating discussion of the possible effects of alcohol at the intracellular and physiochemical membrane level. Schulman, Zurek, and Westerfield have a succinct article on the metabolic pathways of alcohol, as studied with isotope tracer techniques. There are several short articles on the possible relationship of vitamin deficiency and the etiology of alcoholism.

Ten articles on the medical, psychiatric, and milieu therapy of alcoholism follow in the book's second section. Koppányi has a particularly good review of the treatment of alcoholic inebriation and alcoholic coma. Alcoholic withdrawal syndromes, subjects of importance though rarely written of, are considered in two articles. There are two reports on the use of azacyclol and meprobamate in alcohol therapy. Among several articles on the psychiatric aspects of alcoholism, Jackson Smith's paper on the choice of treatment procedure in alcoholics stands out. He stresses the problems inherent to the alcoholic patient-doctor relationship. All authors agree as to the efficacy of antabuse and Alcoholics Anonymous as primary tools in the therapy of alcoholism. They point out that the physician must attempt to evaluate each alcoholic patient individually, and not merely dispose of him as one of the marginal members of society. This monograph is a worthwhile and permanent contribution to the literature on alcoholism, and raises numerous possibilities and questions which no doubt other workers will consider in the future.

Five A.M. By JEAN DUTOURD. 173 pages. Cloth. Simon and Schuster. New York. 1956. Price \$3.00.

This is an excellent French novel, describing one specific situation: the torturing thoughts after awakening. With amazing clinical correctness the author (though obviously completely uninformed of the psychiatric meaning) reproduces the gloomy thoughts of "morose delectation" in a young man. The book is a proof of the thesis that the real writer (as opposed to the typewriter pounder) intuitively knows unconscious facts. No greater compliment can be bestowed on a writer than the statement that his fictional characters act clinically correctly.

Behavioral Analysis. Analysis of Clinical Observations of Behavior; as Applied to Mother-Newborn Relationships. By DAVID M. LEVY, M.D. xxxiv, and 370 pages, summaries, general appendix and index. Cloth. Thomas. Springfield, Ill. 1958. Price \$9.50.

This investigation had its beginning in the study of the mothers of patients who were seen in the practice of child psychiatry. After some years of trial, a series of questions was selected to ascertain maternal attitudes; and, after several studies on selected groups, these questions were used for the main investigation, by a standardized interview, of a group of 19 mothers in four hospitals, heterogeneous as to national origin, religion, education and economic status. This main study also involved the use of rating-scores of maternal attitudes, obtained by observation of the mothers and infants in the neonatal period. A trained observer recorded the behavior of each mother and baby during two or three feeding or nonfeeding periods, with special reference to the mother's response to baby, nurse or others. The scores derived from the ratings and from the interviews were compared for significant correlations. Sucking be-

havior, the mother's methods of stimulating the baby to suck, the infant's resistance to sucking, the mother's behavior when experiencing pain and frustration, and her displays of affect and annoyance were studied very closely.

The problem is the working out of a method of isolating, identifying and quantifying an attitude in relational behavior—which is very limited—between the mother and the newborn. The numerous details of the investigation concerned many questions which had not been asked before.

Each chapter remains largely as it was written originally—without knowledge of the later findings. The reader can thus share the author's trials and predicaments and, thereby, attain a firmer grasp on, and arrive at a more valid critique of, the data and the method of analyzing them. Before each new problem, the reader can thus think about his own solution of the previous investigation.

In this book, a splendid piece of work has also been done by recognizing the implications of the observations, and the relevance of the work, of other research studies.

The Scent of New-Mown Hay. By JOHN BLACKBURN. 221 pages. Cloth. Morrow. New York. 1958. Price \$3.50.

This story has all of the elements, including a mad scientist, usually to be found in the wildest melodramas. Because of the author's careful writing, however, it becomes not only an excellent tale of suspense, but also a not implausible psychological novel. In a nightmare world, where there is (quite literally) something in the wind, one also finds very real people, and a credible sequence of events throughout.

Perspectives in Personality Theory. HENRY DAVID and HELMUT VON BRACKEN, editors. 435 pages. Cloth. Basic Books. New York. 1957. Price \$6.50.

In the present volume, 22 contributors discuss in some detail at least 25 different theories or views about personality which range from the "tough-minded" empiricism of some of the English and American psychologists to the vague, metaphysical speculations of the German "stratification" and French "existentialist" theorists. Of the various countries represented, England, France, Switzerland, and Italy are foremost, with frequent asides about American work. As might be expected, the clash of so many viewpoints is discordant and polemical. The primary battle lines are drawn between the empiricists, who advocate a science of personality, and the intuitively and metaphysically oriented phenomenologists, who insist that scientific method must give way to intuition. The former are forcefully and clearly championed by Eysenck and Franks of England, while the latter are bravely supported by Wellek and Lersch of Germany,

among others. While attesting eloquently to the fact that many psychologists have many differences of opinion about personality, the present volume does not present sufficient exposition to enable the reader to see exactly what it is that a given theorist thinks, or the evidence that leads him to do so. However, it is informative for the American reader, who is sometimes prone to forget that considerable effort is being expended on these matters outside the territory bounded by Yale and the University of California.

The Tents of Wickedness. By PETER DeVRIES. 276 pages. Cloth. Little, Brown. Boston. 1959. Price \$3.75.

This book, like DeVries' earlier ones, is elaborate, erudite, amoral and light-hearted foolery. It concerns a newspaper advice columnist who fancies himself as a fixer-upper of lives, and tries to fix them up on psychoanalytic lines. *THE PSYCHIATRIC QUARTERLY* should not find it necessary to disclaim having printed the paper (quoted by the narrator) by "a Dutch practitioner named Van Kuykens," advising that "There are times when the quickest way to bring a man down to earth is to blow him sky-high"—although there may be something to it at that. Our hero tries it on two subjects, with results that make the story. It is a very amusing story, conceding some slight elements of both the sadistic and the masochistic. The caricature of psychiatry is one over which no offense need be taken; the sophisticated reader—and this book is not likely to have any other kind—will recognize it as a good-natured lampoon. The book includes some masterly parodies of modern verse from Edna St. Vincent Millay to Dylan Thomas. It conveys, incidentally and maybe unintentionally, another excellent fictional lesson of the dangers of amateur tinkering with the psyche. It is heartily recommended.

Psychological Problems in Mental Deficiency. By SEYMOUR SARASON. 678 pages. Cloth. Harper. New York. 1959. Price \$6.50.

For a number of years one of the classic texts in the area of mental deficiency has been this work by Sarason which now enters a third edition. The reasons why psychologists regard it as an authoritative text are many. For example the breadth of topics covered, ranging from diagnostic concerns to therapy, is excellent. The employment of psychological tests in the evaluation of deficiency is carefully and intelligently explored. Above all, perhaps, is the emphasis upon the behavioral continuity of the defective and the normal individual, with the focus upon the psychological problems of the defective.

The chief importance of the third edition is the inclusion, as Part II of the book, of a monograph written jointly by Sarason and Thomas Gladwin, an anthropologist, that was originally published as a special issue

of the *American Journal on Mental Deficiency*. This monograph, which deserves the widest circulation among those who are involved with mental defectives, attempts to review the available information relevant to the social-cultural variables, or background, of mental deficiency. It is probably one of the most scholarly, thorough and penetrating analyses of its kind to be published. Its impact is such as to urge the greatest caution in the evaluation and diagnosis of mental deficiency. One refrain that the applied psychologist needs harken to is the lack of information concerning the relation between test and nontest behavior, and the practical impossibility of separating, at the present time, the genetic and environmental bases of "intelligent" behavior. One persistent and persuasive plea the authors make is for extensive and adequately conceived, basic research with mental defectives—a plea that this reviewer would firmly endorse.

Since Eve. By STANLEY R. BRAV. 204 pages. Cloth. Pageant. New York. 1959. Price \$3.00.

Dr. Brav is widely known for combining an interest in personal and family relationships with a profound knowledge of the Scriptures. In *Since Eve*, he derives modern Judeo-Christian sex morality from a study of the Old Testament. Today's code, he holds, is foreshadowed in numerous Biblical precepts and examples. He illustrates with selections ranging from Genesis through the minor prophets. The translations are his own and are beautifully done. Rabbi Brav notes that the Scriptures exalt sex in marriage and present no basis for shame in it. For this point alone, the psychiatrist who deals with prejudice on this subject should find this book most useful.

Theories of Personality. By CALVIN HALL and GARDNER LINDZEY. 572 pages. Cloth. Wiley. New York. 1957. Price \$6.50.

For a number of years there was an inexplicable omission in the yearly outflow of psychological texts—a competent, serviceable book on the theories of personality has been lacking. Hall and Lindzey have written what will now probably be considered the definitive text for the undergraduate course, as well as an informative book for the sophisticated layman. It is unexcelled in its dispassionate exposition, discriminating in its editing of essentials, judiciously catholic in its outlook, but sensitive to the demands of logic and scientific methodology in its critical appraisals. Approximately 12 major viewpoints are described, some for the first time in a readily accessible and readable fashion. For example, succinct and lucid discussions of factor analytic theory and illustrative research, and of Sheldon's constitutional theory are included. And of course, the traditional topics are there: Freud, Jung, Adler and the neo-Freudians, Lewin,

Rogers, Allport, Murphy and Murray, and even the behavioral theorists. A pleasant and encouraging surprise to the more rigorous-minded, accustomed to the usual vagaries of personality theorists, is the refreshing introductory chapter on the nature of theory construction, and the logical tests that any respectable theory must meet. In short this is a work that cannot be ignored, and that should become a standard text in its area.

The Black March. By PETER NEUMANN. 312 pages. Cloth. Sloane. New York. 1959. Price \$4.00.

The Black March purports to be the story of the Nazi education, indoctrination and military career of an SS man who participated in the advance and retreat in Russia. It is described on the dust jacket as the "candid autobiography of a junior SS officer." Since this book is not well-written, and is unpleasant, even sordid, it is hardly worth general reading if it is not authentic; and it does not readily establish itself as either fact or fiction. The ending is suspiciously dramatic for fact. Regardless of its authenticity, the reader interested in psychology may find *The Black March* worth looking at; under the circumstances, the reviewer sees no good reason to recommend it to the nonprofessional.

Race: Science and Politics. By RUTH BENEDICT. 206 pages including index. Paper. Viking. New York. 1959. Price \$1.25.

Race: Science and Politics is, as Margaret Mead remarks, "simplified but never superficial." It was first published after the outbreak of World War II but before our entry into it, and it was later revised during the war. The examples Dr. Benedict gives to illustrate misuse of racial concepts are drawn, therefore, from Nazi ideology. The Nazi tenets and their dreadful results are things that a too-forgetful world would do well to remember. With the later UNESCO *Statement on Race*, this is a fine basic orientation volume for the beginner in social or medical science and for the general reader. It is excellent mental hygiene.

Annual Review of Psychology. Volumes 7, 8, 9, 10. P. R. FARNSWORTH and QUINN McNEMAR, editors. 448, 502, 543 and 520 pages. Cloth. Annual Reviews, Inc. Palo Alto, Calif. 1956, 1957, 1958, 1959. Price \$7.00 a volume.

Readers familiar with these annual reviews know that the material in each volume represents a careful, and at times, nearly an exhaustive, sample of research relevant to the behavioral sciences published during the preceding year. Some of the topics are, vision, hearing, learning, personality, social psychology, industrial psychology, counseling, physiological psychology, statistics, and behavior disorders. Each section is prepared by an acknowledged authority. For readers of this journal, the sections devoted to psychotherapy, abnormal behavior, personality evaluation, and developmental psychology are of special interest.

An interesting addition to the 1958 and 1959 volumes is a chapter summarizing recent developments in Russian psychology. Until the last few years only brief and fragmentary glimpses of psychological research in Russia have been available in this country. There has been a growing suspicion among many western psychologists that Russian psychology should not be so lightly slighted. Now that the spotlight has been turned upon Russian scientific achievements, the Soviet psychologist has been receiving his share of attention in the American scientific journals. In the last two or three years, several fine summaries of experimental work in special areas of psychological research have been published. Now the annual reviews include more general summaries.

Of particular interest in Volume 10, is the review of diagnostic procedures, in which again the Rorschach continues to predominate, both in the number of reported researches, and in the number of negative findings. The review notes, interestingly, that the growth of objective tests is proceeding rather rapidly—an urgent need. The 1959 review of research in psychotherapy reveals the continued growth of a more sophisticated, scientific approach to the evaluation of therapy, although the content appears as disparate and un-co-ordinated as ever.

The 1958 issue includes Jensen's survey of work in the area of personality. It may come as something of a shock to the clinician to observe his rejection of all research based upon the Rorschach, which he argues "has nothing to show for its applications in the personality field." He provides a provocative account of the analysis of personality by objective tests.

Wright, surveying work on behavior disorders in the 1957 volume, suggests that the rapid development of psychobiological research, for example, in the experimental induction of "model psychoses" with drugs, promises new sources of hypotheses about abnormal disorders and methods for testing them. This reviewer is encouraged by the ever-increasing number of well-designed behavior researches, but is dismayed at the prospect of becoming adequately acquainted with them—an attitude occasionally reflected in the various surveys.

These reviews are necessities for the professional psychologist who wishes to maintain a reasonable perspective in the increasingly complex maze of theoretical and research publications in psychology.

Naming-Day in Eden. By NOAH JONATHAN JACOBS. 159 pages. Cloth. Macmillan. New York. 1958. Price \$3.95.

Naming-Day in Eden is a happy-go-lucky excursion principally into the territory of philology, with side trips into anthropology, psychology, mythology and various other disciplines. Mr. Jacobs speaks more than a dozen languages himself, was chief of the translation department for the Nurem-

burg trials, and is currently leaving the position of librarian of the linguistics department of the University of Jerusalem to become a research fellow at the University of Seville, Spain. Adam consequently names the animals in half a dozen languages. The result is enlightening and amusing from the beginning where Adam apricates in Eden through the point where he fails to elenchize Eve with baculine arguments—and on through the Fall and Adam's problem with a world in which there was a difference between good and evil. (For the benefit of doubters, "apricate," "elenchize" and "baculine" are English—Webster says they are English—though "elenchise" is an intransitive verb. Jacobs delights in this sort of vocabulary trick.)

This book is full of interesting and sometimes illuminating information such as the fact that "the Devil . . . has learned to play all the instruments in the orchestra, although having a marked preference for the French horn." The psychiatrist who has a smattering of semantics and who likes to take an excursion into semantic territory now and then should have a good time with this book.

Your Doodles and What They Mean to You. By HELEN KING. 206 pages including index. Cloth. Fleet. New York. 1957. Price \$3.95.

The author of this book is a professional handwriting analyst and an authority on graphology. Her volume is a partly amusing popular discussion of doodling and an at least semi-serious outline of its possibilities in the way of character analysis. The reviewer thinks that she overestimates what can be determined from doodling in the present state of psychological knowledge. She includes a review of articles on doodles, including scientific articles, which the serious student may find useful.

Just Murder, Darling. By JAMES A. BRUSSEL. 192 pages. Cloth. Scribner's. New York. 1959. Price \$2.95.

Just Murder, Darling is a slick, polished, cheerfully-sadistic little book by a well-known psychiatrist who is an assistant commissioner of the New York State Department of Mental Hygiene. The reviewer thinks he must have had a wonderful time writing it and thinks numerous colleagues (and some jealous husbands!) will have an equally wonderful time reading it. It will not be discussed here as a piece of psychological fiction. Dr. Brussel can argue the dynamics and the character structures of all concerned elsewhere. The reviewer has no doubt that there will be argument, even about the end-stage of the revenge, and he suspects the author will enjoy that also. The author, of course, knows his syndromes and is painstakingly careful to produce psychiatrically-accurate pictures, although some will quarrel with his concept of one of the character disorders.

The writing job is professional, which is to be expected, since the author has been active both as a scientific writer and as a teller of tales all his

professional life. His long preoccupation with the fashioning of crossword puzzles explains one phase of his style. The reader who is on the alert for something new will also be delighted to discover that the psychiatrist turned writer has performed the hitherto unrecorded feat of quoting from a book that has not yet been published. A typographical error on page 122 will irk Dr. Brussel, for, in all respects, this is a well-gotten-up book.

Not only his many colleagues, but others, whether or not they know the author, will find entertainment in this book. It is a very skillfully told story of an attempt to commit the perfect crime; and a lot of people are due to enjoy it in an algolagniac sort of way.

Religions of the Ancient East. By ÉTIENNE DRIOTON, GEORGES CONTEXAU and JACQUES DUCHESNE-GUILLEMIN. 164 pages. Cloth. Hawthorn. New York. 1959. Price \$2.95.

This survey of ancient religion is Volume 141 of *The Twentieth Century Encyclopedia of Catholicism*. It bears the *imprimatur* of the Vicar General of Westminster. The non-Catholic student, however, will find it very difficult to trace sectarianism in this excellent book. There are apparently objective, if simplified, discussions of Egyptian religion, the religion of western Asia, and that of Iran. Among other topics is the relation of the ancient Persian faith to Israel and consequently to Christianity. The book is an elementary but very enlightening survey of material of interest to any social scientist concerned with the religious thinking of mankind.

Your Memory—Speedway to Success in Earning, Learning, and Living. By O. W. 'BILL' HAYES. 95 pages. Cloth. Exposition. New York. 1958. Price \$2.75.

This very short, easily read, appropriately illustrated course in memory training is a concise abstract of the more complete books on the same subject. Its clarity is heightened by lack of details.

Reveille For A Persian Village. By NAJMEH NAJAFI and HELEN HINCKLEY. 273 pages. Cloth. Harper. New York. 1958. Price \$4.00.

Reveille for a Persian Village could be described—perhaps not entirely accurately—as a social worker's book. Najmeh Najafi went into a backward village, equipped with an American education, a wealthy family in the background, and vast enthusiasm. This book is a report of how she, at first single-handed, and then with workers she trained herself, brought the hamlet from a primitive state to the beginnings of modernity. A Moslem and a native Persian herself, she worked in the framework of the village's own national and religious heritage. In a world in which, from east to west, there seem to be almost innumerable societies undergoing painful transitions from ancient to modern ways, this is a valuable report. It is also to be recommended for numerous examples of insight and of tactful personal relations.

Samuel Pepys in the Diary. By PERCIVAL HUNT. 178 pages. Cloth. University of Pittsburgh Press. 1958. Price \$5.00.

This is an attempt to reconstruct the personality of the man, Pepys, from his famous diary. It relies solely on the diary where anybody can find the original material, but the material here is organized in a fashion the ordinary reader lacks the time and the ability to undertake. Pepys emerges as a vivid and likable personality. Mr. Hunt has created an extremely readable book which almost anybody should enjoy, but the reader will find scanty clues in it to Pepys' inner motivations and inner life. With all the self-revelation of the diary, material for this part of the personality reconstruction should not be lacking in it.

The Darkest Bough. By ANNE CHAMBERLAIN. 186 pages. Cloth. Bobbs-Merrill. Indianapolis and New York. 1958. Price \$3.00.

This is a chilling story of a tightly-knit family group beset by a psychopathic outsider who is brought into their circle. His effect on the group, particularly on the mentally defective boy of 14, makes for a highly dramatic tale of suspense. The author's insight seems generally good; her prose style is original and beautiful, yet easily read. The reviewer recommends her story.

Dewey Death. By CHARITY BLACKSTOCK. 285 pages. Cloth. William Heinemann Ltd. Melbourne, London, Toronto. 1956. Price \$3.25.

Dewey Death deals with the goings-on in London's "Inter-Library Despatch Association" offices. The characters, including the psychopathic killer, are not too plausible; the plot drags in spots, and as a mystery thriller, it leaves much to be desired.

Toward Maturity. The Psychology of Child Development. By MARIE I. RASEY. xii and 242 pages. Paper. Barnes & Noble. New York. 1957. Price \$1.25.

Dollard has pointed out that "We begin dimly to see that psychology begins wrong end to if it starts to study the individual mental life apart from the social contexts." In *Toward Maturity* Marie I. Rasey has dealt inspiringly with the entire field of developmental psychology in a refreshing and intelligent manner. Her quotations and references directly concern themselves with the topic at hand. She writes on the child's personality, his ways of action, his daily living, and the world around the child in terms that are insightful and meaningful. The degree to which the bibliographical materials are kept subservient is itself truly an achievement. Miss Rasey is obviously a woman trained well in science, blessed with common sense, and experienced in teaching; and the book breathes a cooling and sound approach into the stickiness of much psychological jargon.

Burning Water. By LAURETTE SÉJOURNÉ. 192 pages including index. Cloth. Vanguard. New York. 1957. Price \$6.00.

The usual inquiry into non-Christian religion follows a course of tracing the spiritual elements back to a primitive structure of things tangible. Symbols have phallic or nature sources. Rituals may represent a gradual spiritualization. The path traced by Laurette Séjourné is in the opposite direction. An archeologist living in Mexico, she starts with the savage sacrifices of the Aztecs and finds that they had a far more spiritual origin. The tearing out of the human heart on the dreadful Aztec altar, says the author, represents what originally was a more spiritual sacrifice—that of individual atonement before the god. The Aztecs, she thinks, because of their savage origin, were responsible for the turning of a spiritual concept into a ritual of mass killings in honor of the gods. The student of comparative religion in particular and the student of human culture in general should enjoy this book.

Power and Community. By ROBERT STRAUSS-HUPE. 128 pages. Cloth. Praeger. New York. 1956. Price \$3.00.

The author, professor of political science at the University of Pennsylvania, promotes the thesis that there is no scientific basis for postulating the existence of a "power-oriented personality." He holds that the pursuit of power for power's sake is a symptom of social disintegration, and adduces a historical-sociological argument. He is frequently correct on the basis of reasons unfamiliar to him; "the power-oriented" personality of the psychopath, the reviewer believes, is often a pseudo-aggressive defensive cover for masochistic vicissitudes.

Handbook of Toxicology. Volume IV, Tranquilizers. RUDOLPH M. GREBE, editor. 120 pages. Paper. Saunders. Philadelphia. 1959. Price \$4.00.

This useful volume concerns the drugs variously known as tranquilizers, ataractics and phrenopractics. The justification for devoting a volume on toxicology to them is in the toxic side effects encountered in administration. The volume covers in tabular form information on most of the new drugs in current use or under current experimentation. A sample entry (promazine hydrochloride) gives a note on a trade name; the molecular formula and weight; a diagram of chemical structure; a notation of physical and chemical properties; paragraphs on animal and clinical pharmacology, remarks on toxicity in animal and man; a note as to an antidote; and 10 references to the literature, the latest entry of which is 1957.

This is a very useful book for anybody dealing with the new drugs or with reports concerning them.

Sam. By LONNIE COLEMAN. 245 pages. Cloth. McKay. New York. 1959. Price \$3.95.

This is a brilliantly written novel on homosexuality that describes, clinically correctly, certain aspects of the disease, and—at the same time—promotes just as many dangerous misconceptions. The masochistic conflicts of homosexuals are presented; and still, at the end, the impression is promoted that two middle-aged homosexuals can be happily united in a marriage-like union. The thesis is at total variance with experience: (a) Homosexuality is a "youth movement," hence middle-aged homosexuals are practically never attracted to one another; and (b) the inner conflicts make any stable relationship impossible.

The book also contains other weaknesses; but that the author has ideas slightly out of the ordinary is proved by the fact that he also attempts something novel for fiction—a description of the jealousy aroused in the husband by a wife who has a platonic, homosexual friend. Most interestingly, he says: "I read in a book somewhere that homosexuals are all very sick people. They basically hate themselves, and their falling in love is actually a desire to destroy each other and therefore themselves." It is too bad that the author does not mention his correct source.

The Jewel in the Lotus. By ALLEN EDWARDS. 293 pages including bibliography. Cloth. Julian. New York. 1959. Price \$6.50.

This book is less a historical survey than a collection of sexual folklore. The cultures it concerns are mostly those of medieval to comparatively recent times in the Moslem world and India. Many of the alleged sexual customs are adduced on the evidence of Sir Richard Burton's translation of *The Book of the Thousand Nights and a Night*. But these tales include more fantasy than fact, with some of the incidents the sort that in the western world are confined to smoking-room stories. There is much hearsay, much doubtful information, much biased presentation, and some downright inaccuracies. The alleged customs of the Turks are presented almost entirely from the points of view of their enemies.

Nevertheless, the social scientist can find some material of limited value here. This is because the book is a condensed and handy description of much custom and fantasy foreign to the western world. It is a sort of anthology of material that would require great time and effort to find and study in its widely scattered sources; and much can be inferred from it concerning the norms of sexual behavior in the cultures concerned—if one remembers that the compilation is considerably less reliable than even a Kinsey report.

The Jewel in the Lotus is a most unfortunate title. It is a translation of an invocation that is commonly understood in the Occident to be

the opening words of a Buddhist prayer or rosary. In modern Buddhist religious thought, the jewel in the lotus is a spiritual concept. Edwardes gives it, not its Buddhist meaning but that of far less than spiritual Hindu sex worship. The result is something like writing a book on western sexual customs and "dirty" stories and entitling it *Christian Meditations* or something similar. The result is also something that will be bought as pornography, not serious work.

Elementary Statistics With Applications in Medicine and the Biological Sciences. By FREDERICK E. CROXTON. 376 pages including index. Paper. Dover. New York. 1959. Price \$1.95.

Amusements in Mathematics. By H. E. DUDENEY. 258 pages including index. Paper. Dover. New York. 1959. Price \$1.25.

The Canterbury Puzzles. By H. E. DUDENEY. 255 pages including index. Paper. Dover. New York. 1959. Price \$1.25.

Mathematical Puzzles of Sam Loyd. Selected and edited by MARTIN GARDNER. 165 pages. Paper. Dover. New York. 1959. Price \$1.00.

Four interesting and useful books on mathematics are brought out in paper covers by Dover Publications.

Croxton's *Elementary Statistics* is a very practical publication which this reviewer has used for some years. It is intended to cover the procedures needed for the writing or understanding of a statistical paper. The author is a well-known authority; and his book is adapted both for reference and for teaching. He assumes that the reader has no previous acquaintance with statistics and only a modest knowledge of mathematics in general. The volume is thoroughly illustrated with graphs, diagrams and tables; and the appendices give the tables most commonly used in the simpler statistical procedures. The reviewer enthusiastically recommends this book for every medical library. The price is exceedingly reasonable for a book of this type.

The two volumes of Dudeney and the one by Martin Gardner are designed for the amateur mathematician's lighter moments. All three contain material originally printed 40 years ago or more. There are puzzles and exercises on a wide variety of mathematical topics ranging in the case of Dudeney's books from arithmetic and algebra to topology, and topics that the author himself failed to classify, and labeled "miscellaneous." Solutions are given for them all.

The *Mathematical Puzzles of Sam Loyd* were selected and cited from an encyclopedic collection which was published privately in 1914. They cover everything from a race between a cat and a dog to military problems involving the chess board.

The normally busy person will hardly go through the three puzzle volumes, puzzle by puzzle, and one after another. They are ideally suited,

however, for random attention when somebody with a mathematical turn of mind has an hour to spare. They would be ideal for the amusement of an invalid with mathematical interests.

The unsophisticated reader can also learn a great deal about what mathematics is about from these puzzle collections.

Psychopharmaca. A Bibliography of Psychopharmacology, 1952-1957.

By ANNE E. CALDWELL, M.D. 258 pages. Paper. U. S. Dept. of Health, Education, and Welfare. Washington, D.C. 1958. Price \$1.50.

This five-year bibliography was compiled for the Psychopharmacology Service Center of the National Institute of Mental Health and can be obtained by purchase from the superintendent of documents at the Government Printing Office. The subject-list of drugs has more than 65 headings. Trade names are given under the principal headings. There is a drug index. The articles cited are entered under the main subject list, under an ancillary subject list of special conditions, and under an author list. There are references to approximately 2,500 articles published between January 1952 and December 1956. There is an incomplete listing for 1957. Foreign titles are given in the original, followed by translations.

This publication should be of use to all laboratory workers and clinicians engaged in research or treatment involving the "tranquilizing" drugs.

The Holy Barbarians. By LAWRENCE LIPTON. 318 pages, with illustrations. Cloth. Messner. New York. 1959. Price \$5.00.

The Holy Barbarians are the hipsters of the Beat Generation who have come upon the scene in a time of crisis, "not with the weapons of war, but with the songs and ikons of peace." This partisan study is certain to leave readers with a better knowledge and understanding of the attitudes, behavior and writings of that small, but howling group, the Beatniks.

Throughout, there are well written sketches, personal histories, anecdotes and dialogue that are informative and at times highly amusing. Mr. Lipton does not fare as well, however, in other areas. Although he may offer certain readers an approach to the content and sound of the writings of the Beat, his evaluation of the hipster's prose and poetry seems boisterous and hollow. His logic and attempts at defense in general seem precarious and unconvincing. However, the study aims to be a thorough one, and it will certainly help clarify many issues regarding the life and world of the Beat. Mr. Lipton includes a glossary of Beatnik jargon to help the square along as he reads through this interesting and timely book.

Anatomy and Physiology. By EDWIN B. STEEN and ASHLEY MONTAGU. 332 pages including index. Paper. Barnes & Noble. New York. 1959. Price \$2.50.

Volume 1 of Steen and Montagu covers cells, tissues, integument, skeletal, muscular, and digestive systems, blood, lymph and the circulatory system. The authors are well-known teachers of anatomy and physiology. Their book is intended for students of the biological sciences, nursing, physical education, medicine and dentistry. It is intended for instruction and reviewing, and contains a tabulated bibliography and a quick reference table to enable the student to turn from a topic treated here in outline to the pertinent section of any of nine standard textbooks. The volume is well printed. It is beautifully illustrated and is carefully edited. It should be of great use and value to the reader for whom it is intended.

Man of Montmartre. By STEPHEN and ETHEL LONGSTREET. 408 pages. Cloth. Funk & Wagnalls. New York. 1958. Price \$4.95.

Man of Montmartre, based on the life of Maurice Utrillo, is a novel of the attachment of an illegitimate child to his mother. The illegitimate child happened to be a painter of genius. The authors were acquainted with both Utrillo and his mother, and their book is thus something like a fragment of a case history. Utrillo was an alcoholic and probably a schizophrenic. This novel tells his story with a good deal of insight, and the psychiatrist should be interested.

Lover Boy. By STANLEY and JANICE BERENSTAIN. 160 pages. Cloth. Macmillan. New York. 1958. Price \$2.50.

This is a sardonic and clever chronicle in cartoons and pseudoserious advice from the time of setting up housekeeping to what the perpetrators call "the golden years." Both cartoons and "serious" text are by a husband-wife team but it is the wife's view that wins. The American husband either is or can be a jackass on many counts. *Lover Boy* is a chronicle of his more asinine moments. There is a good deal of psychological insight in this; but it does not take a specialist to enjoy it.

Chamber of Love. By GIOVANNI BOCCACCIO. 158 pages. Cloth. Philosophical Library. New York. 1958. Price \$2.75.

This small book is made up of selections from the *Decameron* and other writings of the man who fathered modern prose fiction. It includes discussion in conversation, chiefly on the subject of love, that is on the order of the well-known discussions which open and close each day in the *Decameron*. It is less profound, in fact, than some of the *Decameron* discussions but can be enjoyed as a pleasant diversion.

Beyond Human Knowledge. By RUDOLF VON URBAN, M.D. 254 pages. Cloth. Pageant. New York. 1958. Price \$5.00.

Dr. von Urban is a psychiatrist and neurologist. His book, however, although written against a medical background, is more of a religious than a scientific work. He says: "the final purpose of our creation is this: the union of the creative spirit, the human soul, with the increased spirit, the Infinite Person of God."

The Lines Are Drawn. By GERALD W. JOHNSON. 224 pages. Cloth. Lipincott. Philadelphia. 1958. Price \$4.95.

A collection of the Pulitzer Prize cartoons since 1922. The book confirms the facts that history moves fast (some cartoons already need explanation), that cartoon satire is a powerful weapon, finally that (to quote from the jacket) "Pulitzer Prize judges have so consistently shied away from the controversial issues that this book appropriately could have been called 'Drawing Away.'"

Can An Adult Change? By R. L. SUTHERLAND. 27 pages. Paper. The Hogg Foundation for Mental Health. The University of Texas. 1957. Price 25 cents.

This pamphlet enumerates neurotic difficulties, and advocates change by self-understanding, without denying the value of psychiatric therapy. The contradiction seems not to be conscious to the author.

A Short History of Psychiatry. By ERWIN H. ACKERKNECHT. 98 pages including index. Cloth. Hafner. New York. 1959. Price \$3.50.

Ackerknecht's *A Short History of Psychiatry* is a very condensed but adequate outline, starting with ethnological comments, proceeding to Greco-Roman psychiatry and eventually closing with a very brief discussion of present-day practices. The outline covers most of the important names in psychiatry from Soranus of Ephesus to the modern psychosurgeons. Ackerknecht, who was in the United States for some 16 years, has now returned to Europe where he is professor of the history of medicine at the University of Zurich. This book is consequently a translation from the German. It is far too compressed to comprehend the major developments of psychiatry and their significance, but it can be unreservedly recommended for quick reference, and the reviewer thinks it belongs in every psychiatric library.

The Nuremberg Trials. By AUGUST VON KNIERIEM. 561 pages. Cloth. Regnery. Chicago. 1959. Price \$12.50.

The Nuremberg Trials covers what are known as the 12 subsequent cases. They were prosecutions conducted before "exclusively American judges," after the trials of the principal war criminals. von Knieriem

deals chiefly with the legal aspects of the subject. He thinks some of the 12 verdicts were based on "mere political desirability" or on "ethical appeal." The book is of principal interest to students of international law. It is of only slightly less interest to others concerned with human ideals and with the human habit of rationalization. Not the least important feature of this book is the presentation of a German legalistic point of view. The author himself was acquitted by the Nuremberg tribunal.

The Cult of the Mother Goddess. By E. O. JAMES. 300 pages including index. Cloth. Praeger, New York, 1959. Price \$6.50.

Professor James has written a short comprehensive and authoritative review of what is commonly accepted in the cult of the Mother-Goddess from the most ancient times to the present. The Mother-Goddess, James thinks, has "met certain of the vital needs of mankind at all times," and the manifestations of her cult from the crudest to the sublime show an unbroken continuity. This is important basic material for the study of historic and present-day human thought; and the report should be of use to any thoughtful student of mankind. There is a good index, an excellent bibliography and adequate notes.

Free Associations. By ERNEST JONES. 264 pages. Cloth. Basic Books, New York, 1959. Price \$5.00.

Ernest Jones was the last survivor of the circle of pupils and intimates who surrounded Freud in the early days of psychoanalysis and later rose to eminence in that new medical specialty. *Free Associations* is the first 11 chapters of what he had intended as an autobiography. He started it in 1944, then suspended work on it with the feeling that the early days of psychoanalysis and the growth of that discipline should center around Freud rather than around his own life-story. With his biography of Freud finally finished in 1957, Jones returned to this book, which he succeeded in carrying only through 1919, closing his eleventh chapter with the tragic death of his first wife. The story as written, however, covers the author's early years adequately: his childhood and education in Wales, his brilliant start professionally as a young doctor, and his experiences as a teacher and practitioner when psychoanalysis was comparatively new. There are extraordinarily well drawn and historically valuable sketches of many who were great in British medical and surgical circles at the beginning of the century. The autobiography also covers his years in Canada and visits to the United States. His notes on the psychoanalytical "movement" duplicate some of the material in his three volumes on Freud but the account in the present book is an excellent summary. Unfinished as it is, this work is an important document for the history of psychoanalysis and psychiatry.

Hoaxes. By CURTIS D. MACDOUGALL. 338 pages including index. Paper. Dover. New York. 1958. Price \$1.75.

The hoax and the practical joke fall well within the scope of psychiatry. MacDougall's *Hoaxes* is a revised version of a book first published in 1940. The text has been amended to include such matters as the exposure of the Piltown Man hoax and comment on Henry L. Mencken's famous history of the bathtub, ranging through 1954. Pertinent material of the World War II years is included, although readers would be well advised to remember the original publication date and note that references to the World War (number unspecified) are to World War I. The author of this volume is a professor of journalism. He has included a sound but surface discussion of the social and individual psychology that makes hoaxes possible. The informed reader can do his own speculating as to the dynamics.

Lunacy and Letters. By G. K. CHESTERTON. 192 pages. Cloth. Sheed & Ward. New York. 1958. Price \$3.00.

The "lunacy" of Chesterton is not the lunacy of psychosis but the lunacy of people in general. The essays in the present volume date to the author's earlier years and are mostly reprints of a newspaper column. They contain a good deal of material of psychiatric and psychological interest.

The Unfinished Story of Alger Hiss. By FRED J. COOK. 184 pages. Cloth. Morrow. New York. 1958. Price \$3.50.

Mr. Cook is to be congratulated for writing a succinct, highly readable and extremely provocative analysis of the Hiss-Chambers case. In some ways, it is more persuasive of Hiss's innocence than Hiss's own book, partly because it is written by a disinterested party but particularly because the inconsistencies and contradictions in the government case against Hiss have been organized in a highly effective manner.

Mr. Cook is no special pleader for Hiss; he is concerned with the grave possibility that an innocent man was convicted. And, after reading the book, it is difficult not to believe in Hiss's innocence. As the author points out, this is due not so much to the strength of the Hiss defense, as to the weakness of the prosecution case. Clearly, we have not yet seen the end of this celebrated case, but Mr. Cook has done an excellent job with the beginning and middle of it.

On Mathematics and Mathematicians. By ROBERT EDOUARD MORITZ. 410 pages including index. Paper. Dover. New York. 1959. Price \$1.95.

This is a very fine book of excerpts for the casual amusement of the mathematically-minded in the way of idle reading. It is also a fine collection of mathematical aphorisms and a good reference work for the location of such aphorisms, and for definitions and condensed descriptions.

The quotations range from Aristotle to Bertrand Russell. There are excellent "chapters" on definitions, on the nature of mathematics, on study and research, on anecdotes about the peculiar people who become mathematicians, on mathematics in science and on paradoxes and curiosities. Most scientists should find this book entertaining, and many will find it useful.

Successful Technical Writing. By TYLER G. HICKS. 294 pages. Cloth. McGraw-Hill. New York. 1959. Price \$5.50.

Successful Technical Writing is intended primarily for the professional who must deal with scientific or technical material. It is also intended for the scientist or technician who writes his own reports. It is concerned, not with what to write about, but with how to write it. Much of the presentation is from the commercial writer's point of view but a good deal of this is adaptable for the scientific writer's purposes. The scientific writer can profit in particular from the chapters on illustrations and tables, and on how to write technical papers. Anybody with a scientific paper to write, who is not sure of his procedure, could make good use of this book.

The New Psychiatry. By NATHAN MASOR, M.D. 155 pages with bibliography, subject index, and author index. Cloth. Philosophical Library. New York. 1959. Price \$3.75.

According to the back flap of the dust jacket, Dr. Masor is a practising physician and surgeon in the Greater New York City area who has written this book to "offer real encouragement to the mentally ill who have been able to obtain no substantial relief from the methods now in use. He believes that he himself has found the answer; and he has no good opinion at all of most specialists in the field: "The orthodox psychiatrist... has forsaken his training in favor of the tangential and circuitous pathways of ascetic dogma, he plunges headlong from theory to practice, neglecting only one important detail, the proving board... The psychological therapist may be an idiot savant who is most profound and learned in ignorance, his studies are unilateral, myopic, predatory and ascetic in the field of mental gymnastic." However, the biological psychiatrist "possesses a conscience and a spirit, and as a result, he presents a challenge to orthodoxy. He is ready to throw away his couch whenever the biochemical breakthrough arrives. He is the coming Messiah in the turmoil of psychic misunderstandings and the clear spring of hope emerging from the cesspools of confusion."

Dr. Masor announces himself as a firm advocate of the biochemical approach. All kinds of mental disorders are described as curable by Dr. Masor's method, which is the administration of Vitamin B12 and thyroid extracts. According to case illustrations these disorders include phobias, schizophrenia, hypochondriasis, psychogenic rheumatism and constitutional psychopathy.

Trial of August Sangret. MACDONALD CRITCHLEY, M.D., editor. 233 pages. Cloth. Hodge. London. 1959. Price 18/-.

The *Trial of August Sangret* is the account of a murder and trial which attracted little attention at the time, as they occurred in England in the war years of 1942 and 1943. August Sangret, of mixed Cree and French-Canadian descent, "shacked up" with a young English girl who loitered about the army camps. Eventually he killed her; he was convicted and executed. The case is of considerable medico-legal interest in the detection of the criminal and of some interest in its depiction of his psychopathic make-up. The report is the usual careful report of the Notable British Trials Series; the editing is competent and the comments of the editor are of interest, both for their moralistic point of view and for their notes on the characters and their backgrounds. For instance, "...the Crees are noted to resort to cannibalism in times of hardship... Indian half-breed troops during the war did not lack courage, but they made troublesome and inefficient soldiers..." Both the account of the trial and the comments are of interest.

Egyptian Religion. By SIR WALLIS BUDGE. 224 pages. Cloth. University Books. New York. 1959. Price \$5.00.

Sir Wallis Budge wrote *Egyptian Religion* in 1899. It was an important book in its day and its reprinting 60 years later is important. It covers adequately the principal beliefs and the principal rites concerned with a thickly populated pantheon. It should be of particular interest to the social scientist who attempts to relate a work of this sort to the writer's own period. Sir Wallis lived at a time when scientific study had brought about a change in the religious thinking of Europe's intellectual leaders from reliance on revelation to a sort of creedless monotheism. Sir Wallis saw such a monotheism underlying the apparent rich polytheism of ancient Egypt. His book is largely a discourse on how "The Belief in God Almighty" underlay the whole fabric of Egyptian religious life. The extent to which there is cause and effect in intellectual environment and historical conclusion is fascinating psychological speculation. It is of interest in this connection that later students do not appear generally to follow Sir Wallis' reasoning in detail, although some underlying belief of the type he describes must have preceded the religious reforms of Ikhnaton.

The Theory of Knowledge. By MAURICE CORNFORTH. 240 pages. Cloth. International Publishers. New York. 1955. Price \$2.50.

This is the third and last volume in a series of treatises on dialectical materialism. It is devoted to an analysis of the evolution of human knowledge, from the "conditioned reflex" to the complex phenomenon of human consciousness. Taking as his thesis the Marxist conception of knowledge,

the author finds that the appraisal and analysis of epistemology comes last in the understanding of the human condition, rather than first, as in some conventional philosophies. Lucidly, concisely, and rigorously written, this volume should prove stimulating and provocative to the reader of a philosophical (and dialectical) bent.

A Prison, A Paradise. By LORAN HURNSCOT. 320 pages. Cloth. Viking. New York. 1958. Price \$3.95.

Diaries of a woman are presented in two periods; unhappy marriage and religious survival. The novel is boring in the first part, and (as even an admiring critic stated in the *New Statesman*) offensive to religious people: "Orthodox Christians... will challenge some of her statements and assumptions..." The book is written under a pseudonym, and purports to be true.

Love and Hate in Human Nature. By ARNOLD A. HUTSCHNECKER, M.D. 272 pages. Cloth. Crowell. New York. 1955. Price \$3.50.

Progressing with ideas of emotional problems which he expressed in his previous book, *The Will to Live*, Dr. Hutschnecker analyzes the forces of love and hate as they effect the self, the group and the future.

The author emphasizes the lack of equilibrium in human emotional expressions; the severe struggle which man endures to express himself as a personality, and the vacillation of emotions under stress and during tenderness. The book is easy reading and has many good thoughts.

When Your Child is Ill. Revised edition. By SAMUEL KARELITZ, M.D. 518 pages including index. Paperbound. Permapbook. 1958. Price 50 cents.

This is a comprehensive survey of childhood diseases written with assurance and authority, and in clear style. The author provides parents with a handy manual which should be helpful in knowing what to do until the doctor comes, what to tell him and how to understand his diagnosis and instructions. Dr. Karelitz literally and skillfully answers 1001 questions parents ask about these illnesses. The book would be a valuable addition to most family libraries.

Emotional Problems of Adolescence. By J. R. GALLAGHER and H. I. HARRIS. 172 pages. Cloth. Oxford University Press. New York. 1958. Price \$3.50.

Two psychiatrists attempt to clarify adolescent problems, only to fall into the usual pitfall of popularizers: They sacrifice too much fact. It is easy to say, "Remember always that kindness antedates psychiatry by

hundreds of years," and to advocate the principles of kindness. What about youngsters bent on self-damage? It is also easy to say, "Adolescents must learn to govern themselves." What about those who refuse? The reviewer thinks it is high time to dispense with friendly phrases—why should the psychiatrist fall into that trap?

Conflict—The Web of Group Affiliations. By GEORG SIMMEL. 195 pages. Cloth. Free Press. Glencoe, Ill. 1955. Price \$3.50.

Addenda are presented here to Simmel's well known *Sociology*. The German sociologist and philosopher (1858-1918) is honored in the foreword as the "Freud of the study of society." Though this is highly exaggerated, Simmel's ideas are interesting for the sociologically-minded.

The Family Medical Encyclopedia. By JUSTUS J. SCHIFFERES, Ph.D. 617 pages. Cloth. Little, Brown. Boston. 1959. Price \$4.95.

The Family Medical Encyclopedia is edited by a former medical editor who is now director of the Health Education Council. He had the assistance of an advisory editorial board which includes the editor of the *Journal of the American Medical Association* and a number of other well-known medical people. The result is a neatly presented and informative volume which appears to this reviewer to be less likely than any other he has seen to encourage either hypochondria or amateur doctoring. Besides its general information, this encyclopedia is something of an elementary medical dictionary. The reader with a high school education or better should find it educational, as well as generally informative. It could, in fact, be used as a hygiene-course reference. There are brief notes on emergency first aid, with stress on situations where the doctor should be called in a hurry. The psychiatric terms are defined satisfactorily, and the short articles on mental illness and related topics appear excellent. The appendix includes a useful quick-reference directory of professional associations and health agencies. As its best recommendation, it should be noted again that self-medication with the aid of this book would be practically impossible.

The Devil's Dictionary. By AMBROSE BIERCE. 145 pages. Paper. Dover. New York. 1959. Price \$1.00.

Ambrose Bierce disappeared 46 years ago in what has since been regarded as one of America's major mysteries. He had been the country's foremost satirist and one of its best-known writers.

The collection known as *The Devil's Dictionary* began as weekly newspaper paragraphs; and its first book form appeared more than 50 years ago. Re-publication of the collection is of interest because of the light it

casts on a fascinating character, and because of the aptness of a good many of the definitions themselves. Bierce's humor was bitter. For instance: "EMBALM, *v. t.* To cheat vegetation by locking up the gases upon which it feeds." These cynical observations are very uneven in quality, but many of them are as fresh as when they were first written.

Bed and Bored. By LAWRENCE LARIAR. 128 pages. Cloth. Dodd, Mead. New York. 1958. Price \$3.50.

Bed and Bored is a collection of picture puzzles "for impatient patients." The reviewer made its acquaintance when he was himself bedridden, and can testify that it is amusing, diverting and on the whole therapeutic. He would suggest, however, that no patient without a high frustration tolerance take the time limits set for some of the solutions too seriously.

Collective Behavior. By RALPH H. TURNER and LEWIS M. KILLIAN. x and 547 pages. Cloth. Prentice-Hall. Englewood Cliffs, N. J. 1957. Price \$6.95.

Turner and Killian examine hypotheses and generalizations in the light of observations of collective behavior, and develop, in this book, a general theory applicable to phenomena in groups of any size and any area of interest. Additionally, their text interprets a wide selection of readings in factors of behavior as illustrative applications of the principles that are developed. The authors deal with the nature and emergence of collective behavior, individual reactions to crises, the crowd process, the nature of public opinion, participation-oriented movement, and the social consequences of social and collective behavior. To the authors, the subject matter of sociology is rightly the human group; and they carry out a scientific analysis of the existence of certain regularities, even irregularities, in group life and in group thought. The book includes sound readings, complete with related text material. This reviewer thinks that *Collective Behavior* uncovers fallacies, oversimplifications, and pseudo-issues, and restates real issues in a field of psychology and sociology that is of increasing importance and significance in our present-day dynamic society.

Aion. By C. G. JUNG. 344 pages. Cloth. Pantheon. New York. 1959. Price \$4.50.

Jung explains this work as aiming "with the help of Christian, Gnostic, and alchemical symbols of the self, to throw light on the change of psychic situation within the 'Christian aeon.'" Jung thinks that historical speculations about time "as the Apocalypse shows," were influenced by astrological ideas and that the Christian eon coincides with the "astrological conception of the 'Platonic month' of the Fishes." He thinks that these concepts relate to the archetypal image of wholeness. This, he remarks,

appears frequently in the products of the unconscious and has forerunners in history. This book is a discourse on that history.

The discussion ranges through comparative religion, astrology and religion, the prophecies of Nostradamus, and the fish in alchemy, to Gnostic symbols of the self and discussion of the structure and dynamics of the self. Jung's aim appears to be to show "how certain Christian ideas look when observed from the standpoint of psychological experience." The terms in which Jung discusses this psychological experience are, of course, strange to most American practitioners of psychiatry. Whatever one's orientation, however, much of the material in this book and many of the conclusions are fascinating. There is a great deal here to illustrate the background of modern mysticism and much which the reader, of whatever orientation, will regard as insight.

Psychopathology. A Source Book. CHARLES F. REED, Ph.D., IRVING E. ALEXANDER, Ph.D. and SILVAN S. TOMKINS, Ph.D., editors. Introduction by ROBERT W. WHITE, Ph.D. 803 and xii pages, and index. Cloth. Harvard University Press, Cambridge, Mass. 1958. Price \$12.50.

This source book was written as a secondary text for courses in abnormal psychology and psychiatry. It consists of 46 pages selected from the psychological and psychiatric literature, each included as an instructive sample of the current periodical literature. Only two of them were written before 1951; more than half carry a date of 1955 or later. The subjects were grouped under five headings: I. Psychopathology and early experience. II. Psychosomatic disorders and neurosis. III. Schizophrenic psychoses. IV. Somatic factors in psychopathology. V. Psychopathology and the social context.

This book does not include papers on shock therapy or lobotomy, areas of research which have been thoroughly explored and evaluated, but favors the more recent developments, stressing novelty, promise and suggestiveness. Contributions are selected to introduce the reader (or student) to the active and complex enterprise of recent investigation and hypothesis in a wide field.

Says Robert W. White in his introduction: "Where once it was hoped to unlock the secret of a disorder, we know now that we must creep up slowly upon its secret and that we must use to the utmost, help provided by scientific methods. In this new climate, the present book is an indispensable teaching aid."

The Art of the Ancient Maya. By ALFRED KIDDER II and CARLOS SAMAYOA CHINCHILLA. 124 pages. Cloth. Crowell. New York. 1959. Price \$5.00.

"The idea," says Carlos Samayoa Chinchilla, "...that the sun needs blood to nourish its energies...is something that in no way could or

should be considered absurd from the [Maya] Indian's point of view." Maya art, like Maya belief, is another expression of these non-absurd absurdities. The Maya sculptor, Señor Chinchilla goes on to say, had unusual mastery of his craft, "but voices that called to him from an unreal world compelled him to twist, elongate, distort and deform the [human and other] figures until they came to represent something that appears many times to have sprung from a nightmare. . . ." These observations are those of an anthropologist and historian. Others have frequently commented that Maya art resembles nothing so much in the modern world as schizophrenic productions. The illustrations in this volume, with the two accompanying short essays, should, therefore, be of as much interest to the art therapist as to the archeologist or the student of human institutions in general.

Young Children in Hospitals. By JAMES ROBERTSON. xii and 136 pages. Boards. Basic Books. New York. 1959. Price \$3.00.

The pediatrics ward in a general hospital is often a place of turmoil, with many sets of lungs trying to shout or scream the others. At other times peace and quiet reign—or so it seems to the casual observer. The children resting so quietly and causing so little trouble are not usually happy children. The child under the age of four is incapable of understanding the necessity of "Mommie" leaving—particularly when the child is sick. The fact of the desertion is all that matters. This desertion brings to the child a sense of outrage, often expressed vocally and loudly, which gives way in turn to feelings of apathy and rejection.

The author believes that mothers should room in with their children when they are in the hospital. Should this not be possible, unlimited visiting should be allowed and encouraged. Many traditional concepts of care are challenged by the author—and solutions are proposed. This reviewer is in hearty agreement with the ideas expressed in this book.

Family Relationships and Delinquent Behavior. By F. IVAN NYE. X and 168 pages. Boards. Wiley. New York. 1958. Price \$4.95.

The author has attempted to measure the influence of the family on delinquent behavior in non-institutionalized adolescents. There are many possible sources of bias present when testing an institutionalized population—and these factors would tend to reinforce the theory that low socio-economic level, broken homes, and poor parent-child relationships lead to delinquency. The method used in Dr. Nye's study was to submit questionnaires to a large numbers of students (a random population) and set up Guttman-type scales for the responses. Anonymity was stressed. The results support to a great degree the popularly-held theories.

The approach of the book is statistical, which removes it from the "light reading" class; but researchers in the problem of delinquency will find these statistics valuable.

Shall Do No Murder. By HOLMES ALEXANDER. 211 pages. Cloth. Regnery. Chicago. 1959. Price \$3.00.

The author of this book is a good reporter and good writer who knows his setting and who describes intelligently the intrigue that can result when a querulous and unscrupulous old man is owner and publisher of a newspaper. Against this authentic setting, however, he has tried to write a suspense novel, with purely psychological motivation. The reviewer has the impression that the author has a very good book acquaintance indeed with certain aspects of psychoanalytic theory, but that he has little insight. A very mechanical "hero," ridden by guilt and impelled by masochism, concerning which there is much claptrap about the death instinct, brings disaster on himself. The bits and pieces of motivation and action fit like wrongly identified parts of a jigsaw puzzle. The ending of the book seems a ridiculous misfit—if the author, by any chance, drew it from life, the real ending is yet to arrive.

The Will To Live. By ARNOLD A. HUTSCHNECKER, M.D. 292 pages. Cloth. Prentice-Hall. Englewood Cliffs, N. J. 1958. Price \$4.95.

The revised 1958 edition of Dr. Hutschnecker's inspirational book, *The Will to Live*, should be received with the same enthusiasm and praise that the original edition met in 1951. The book makes its plea for preventive medicine by illustrating, through narrative case histories, the relationship between emotions and illness. The author stands by the Freudian concept of destructive and creative forces within the personality, and holds that only when the balance is weighted toward the creative drive, will good health prevail. He reviews the theories of stress, anxiety and organ selectivity. He believes that much serious illness can be avoided when people come to grips with their emotions. This book has much to offer both professional and layman.

Great Companions. By MAX EASTMAN. 312 pages. Cloth. Farrar, Straus and Cudahy. New York. 1959. Price \$4.75.

Max Eastman is the son of two ministers of the gospel. He became a crusading Socialist editor and writer and conducted his own affairs of life according to a most unconventional, personal moral code. His book has a scattering of passages which might have been excerpted from a "confessional autobiography," besides a collection of fascinatingly-written reports on contacts, from casual to intimate, with interesting and important personalities of his day. There is material here which casts light on the characters of such men as Einstein, Hemingway, Trotsky and, surprisingly, Freud. Or, if it does not cast light, it reveals how they appeared to an unusually observant and intelligent contemporary. Any student of personality should enjoy this book.

Stress Situations. SAMUEL LIEBMAN, editor. 144 pages. Cloth. Lippincott. Philadelphia. 1955. Price \$3.00.

This small monograph consists of a series of lectures on emotional reactions to stress—intended for the general medical practitioner as well as the resident psychiatric trainee. Masserman discusses emotional reactions to death and suicide; Spiegel describes the nature of catastrophe and its disorganizing effect upon behavior; Robbins outlines the emotional consequences of frustration and failure. Other lectures contribute descriptions of emotional reactions to acute illness, to marriage and divorce, to fertility and sterility. Professional workers as well as informed laymen will find this series of lectures a lucid and concise exposition.

Prelogical Experience. An Inquiry into Dreams and Other Creative Processes. By EDWARD S. TAUBER, M.D., and MAURICE R. GREEN, M.D. xi and 196 pages with index. Cloth. Basic Books. New York. 1959. Price \$3.75.

The authors focus their attention on the prelogical processes; that is, on what the patient tells the therapist in the subtle forms of communication that operate below the levels of awareness, besides what he tells in the logical forms of conscious communication.

The authors' main thesis is to demonstrate that when the prelogical forms of thinking are properly used—intuition, guesses, hunches, day-dreams and spontaneity, forms which do not operate in the logical mode—they have an extraordinary important contribution to make both to the scientific structure of psychoanalysis and to the therapeutic aspect of psychoanalysis. It is assumed also that, as a prelogical matter, dream analysis and interpretation may become the truly effective therapeutic tool that it is capable of being.

This book is lucid, highly readable, interesting and "always stimulating." The good and exceedingly well-stated psychoanalytic conclusions seem to present an obviously practical argument for the authors' approach to the scientific structure of psychoanalysis and therapy.

George III and the Historians. Revised edition. By HERBERT BUTTERFIELD. 304 pages including index. Cloth. Macmillan. New York. 1959. Price \$5.00.

George III and the Historians is a study of how historians write history. It is technical and is of principal interest to the discipline for which it was intended. To the psychiatrist and psychologist, it is a beautiful exposition of how the viewpoints of different observers can produce honest and widely varying pictures of the same set of facts. The book, unfortunately for the student of the mind, does not cover, to any extent, the varying reactions to the most important fact of George III's reign, his mental disorder.

CONTRIBUTORS TO THIS ISSUE

THOMAS V. HOYER, M.D. Dr. Hoyer graduated from the University of Michigan Medical School in June 1951. After a year of rotating internship at the California Hospital, Los Angeles, California, he served for two years in the air force. He was flight surgeon for an air training base and reached the rank of captain. Following this, Dr. Hoyer completed three years (1954-1957) of residency training in psychiatry at Brentwood Veterans Administration Hospital, Los Angeles. At the same time, he was a graduate student at the University of California at Los Angeles, where he received a certificate of postgraduate medical study in the field of psychiatry. Dr. Hoyer is now on the staff of the Veterans Administration Hospital, Marion, Ind., and is scheduled to return to the Veterans Administration Hospital, Los Angeles, on September 1.

JAMES H. WALL, M.D. Dr. Wall has been medical director of the New York Hospital—Westchester Division (White Plains, N. Y.) since July 1, 1946. He is professor of clinical psychiatry at Cornell University Medical College.

CECIL BERESFORD, M.B., B.S., L.R.C.P., M.R.C.S., D.P.M. Dr. Beresford was educated at Christ College, Brecon, and after a short pre-medical course at Bristol University, entered the London Hospital Medical School (University of London) in 1926. He graduated in 1931, obtaining both the medical degree of the London University and the diplomas of the Royal Colleges of Medicine and Surgery of England in that year. After further postgraduate general medical experience as resident at the Southend (Essex) General Hospital, he began his training in psychiatry at Netherene Mental Hospital, Coulsdon. Upon its completion he joined the staff of The Retreat at York as senior assistant psychiatrist, a position he held until World War II. During the war he served for nearly five years with the R.A.M.C., at first as regimental medical officer and later as psychiatric specialist with the 5th Western General Hospital. He was subsequently promoted to lieutenant-colonel when appointed adviser in psychiatry to the Middle East Land Forces, a position he held until the end of hostilities.

He returned to The Retreat after demobilization as consultant in psychiatry and became clinical director in 1951. He has been physician superintendent since 1956.

As well as being the administrative head of The Retreat, now one of the private psychiatric hospitals independent of the National Health Service, he serves on the management committee of a group of state hospitals and on the medical advisory committee of a state psychiatric hospital. He is an active member of the Royal Medico-Psychological Society and Vice-President of the Leeds Regional Board Psychiatric Association.

BURTRUM C. SCHIELE, M.D. Dr. Schiele has been psychiatric consultant to the Veterans Administration Hospital, St. Cloud, Minnesota since 1948. He is professor of neurology and psychiatry and chief of adult in-patient psychiatric service at the University of Minnesota. Born in 1904, he is a graduate in medicine of Colorado University. He had a fellowship in psychiatry at the Colorado Psychopathic Hospital, Denver, then was assistant resident and resident psychiatrist at the Payne Whitney Psychiatric Clinic, New York City. At that time he was assistant psychiatrist and instructor in psychiatry at Cornell University Medical School. He left to take an assistant professorship at the University of Minnesota in 1937.

ROY M. MENDELSON, M.D. Dr. Mendelson was a ward psychiatrist at the Veterans Administration Hospital, St. Cloud, Minnesota when the study of which he is co-author, appearing in this *QUARTERLY*, was written. Born in Chicago, he is a graduate of the College of Medicine of the University of Illinois and has studied at the Menninger School of Psychiatry. He is now a fellow in child psychiatry at the Menninger Foundation.

ALLAN S. PENMAN, Ph.D. Dr. Penman is a member of a firm of psychological consultants in Toronto. He was chief psychologist at the Veterans Administration Hospital, St. Cloud, Minnesota when the paper (in this *QUARTERLY*) of which he is co-author was written. Born in 1920, his college course was interrupted by World War II. He received his bachelor's degree in 1947, his M.S. in clinical psychology in 1948, and his Ph.D. in clinical psychology in 1951, all from the University of Illinois. He trained at the Veterans Administration Hospital at Danville, Illinois before going to the St. Cloud institution.

WILLIAM SCHOFIELD, Ph.D. Dr. Schofield is associate professor of medical psychology at the University of Minnesota and is clinical psychologist at the University of Minnesota Hospitals, Minneapolis. Dr. Schofield received his bachelor's degree from Springfield College, Springfield, Massachusetts and his M.A. and Ph.D. degrees from the University of

Minnesota. He served in the army air force during World War II. He has a diploma in clinical psychology from the American Psychological Association and is a fellow of the Association of Clinical Psychologists. He is consultant for the Veterans Administration hospitals at St. Cloud and Minneapolis and for the Minneapolis General Hospital. He is active in numerous professional groups.

SELWYN BRODY, M.D. Dr. Brody is a psychiatrist and psychoanalyst in private practice in New York City and White Plains, N. Y. He received his B.S., M.D. and C.M. degrees from McGill University, and served a neurological residency at Kings County Hospital, Brooklyn, and psychiatric residencies at Mount Zion Hospital, San Francisco, Worcester (Mass.) State Hospital, and Baldpate Sanatorium, Boston. He held a fellowship in neuropsychiatry at Mount Sinai Hospital, New York City. His personal and training psychoanalyses were at the Boston and New York institutes of psychoanalysis.

His past appointments include instructor at the New York University Medical School, group therapist for the Red Cross, senior clinical assistant in psychiatry at Mt. Sinai Hospital, consultant at the Community Service Society and at the Hawthorne Cedar Knolls School. His present positions are senior clinical assistant, Lenox Hill Hospital, New York City, and chairman of the psychiatric staff, Children's Village (Dobbs Ferry, N. Y.), an institution for disturbed adolescents. He has conducted workshops, and appeared on radio programs for the Westchester Mental Hygiene Association.

Dr. Brody is a diplomate of the American Board of Psychiatry and Neurology in both specialties. He is the author of a number of scientific papers. His societies include the American Psychiatric Association, the American Orthopsychiatric Association, the American Group Psychotherapy Association, the Schilder Society, and the New York Society for Clinical Psychiatry.

ALBERT J. STUNKARD, M.D. Dr. Stunkard is associate professor of psychiatry at the University of Pennsylvania. He was born in New York City in 1922, and received his B.S. from Yale in 1943 and his M.D. from Columbia in 1945. He served a residency in psychiatry at the Johns Hopkins Hospital. Thereafter, he engaged in research in psychosomatic medicine at Cornell University Medical College where he was also psychiatrist for the comprehensive care and teaching program. He is currently spending full time in research and teaching. He is the author of a number of publications dealing with psychological and physiological investigations of human obesity.

JACK ROSBERG, M.A. Mr. Rosberg received his A.B. from San Jose State College, and his M.A. from New York University. After working in direct analysis with Dr. John N. Rosen for several years, he is now in private practice as a psychotherapist under medical supervision.

BERTRAM P. KARON, Ph.D. Dr. Karon is a clinical psychologist engaged in research on psychopathology at Philadelphia Psychiatric Hospital. He received his A.B. from Harvard, his M.A. and Ph.D. from Princeton and did direct analytic work with Dr. John N. Rosen. Dr. Karon has held a research fellowship at the Educational Testing Service, and a United States Public Health Service Research Fellowship at Princeton University. He has been connected with the Akron Psychological Consulting Center, and has been senior clinical psychologist at Annandale Reformatory, New Jersey. In addition to his work on psychopathology, Dr. Karon has recently published *The Negro Personality*, a report of an extended investigation of the personality problems of northern and southern Negroes.

ANTHONY SAINZ, M.D. Dr. Sainz is in charge of the psychopharmacological research unit at Marcy (N.Y.) State Hospital. He was born in Havana in 1915 and is a graduate in medicine of the University of Havana in 1941; he has a law degree and bachelor's degrees in both arts and sciences. His research experience includes work for the Ministry of Public Health of Cuba, the Finley Institute for Research of Havana, and the University of Havana Medical School. He was medical director for UNRRA in the United States zone of occupation in Germany; and, before joining the Marcy staff, was clinical director at the Mental Health Institute, Cherokee, Iowa.

JOSEPH H. GOLNER, M.S. Mr. Golner is a fellow in community mental health at the Massachusetts General Hospital, Boston, and is leader of group therapy at the Community Church, Boston. He is a graduate of Boston University School of Social Work in 1951, and his master's degree is in social science. He had been a group worker for the New England Zionist Youth Commission and a psychiatric social worker at Boston State Hospital before going to Massachusetts General Hospital.

HAROLD M. GEDDES, M.S. Mr. Geddes is psychiatric social work supervisor at the Judge Harry K. Stone Clinic in Brockton, Mass. His master's degree is from Simmons College School of Social Work in 1953. He was a psychiatric social worker at Boston State Hospital and was head psychiatric social worker at Metropolitan (Mass.) State Hospital Children's Unit before going to Brockton.

JOHN ARSENIAN, Ph.D. Dr. Arsenian is director of psychological research at Boston State Hospital and is assistant professor of clinical psychology at Boston University, where he was graduated in 1939. He received his doctor's degree in psychology from Harvard in 1945. He has been at Boston State Hospital since 1947, chiefly engaged in investigating various aspects of group psychology.

STELLA CHESS, M.D. Dr. Chess is in practice in New York City. She is associate clinical professor of psychiatry at the New York Medical College, director of the child guidance clinic at Metropolitan Hospital, chief psychiatrist of the mental retardation clinic of the Flower-Fifth Avenue Hospitals, and consulting psychiatrist for the children's rehabilitation service at the Bird S. Coler Hospital, all in New York City. A graduate of Smith College in 1935, Dr. Chess received her medical degree from New York University in 1939. She is the author of a number of scientific publications, mostly on child psychiatry and including a previous contribution to this *QUARTERLY*. She is a fellow of the American Psychiatric Association and a member of other professional organizations.

ALEXANDER THOMAS, M.D. Dr. Thomas, in practice in New York City, is associate professor of psychiatry at New York University-Bellevue Medical Center, and is associate attending psychiatrist at Bellevue Hospital and University Hospital, New York City. He is a graduate of the College of the City of New York in 1932 and received his M.D. from New York University in 1936. He is a fellow of the American Psychiatric Association and a diplomate in psychiatry of the American Board of Psychiatry and Neurology. He served with the army air force during World War II. He is the author of a number of scientific articles, including a previous contribution to *THE PSYCHIATRIC QUARTERLY*.

WILLIAM MALAMUD, M.D., C.M. Dr. Malamud is president of the American Psychiatric Association. He is also director of research of the National Association for Mental Health, Inc. and of the Scottish Rite Research Foundation. A graduate of McGill University School of Medicine in 1921 with the degrees of M.D., C.M., Dr. Malamud served psychiatric and neurologic residencies at Boston Psychopathic Hospital and at Mount Sinai Hospital, New York City. From 1924 to 1926 he undertook post-graduate studies in Germany, Austria, Switzerland, France and England, primarily in psychiatry, neurology and philosophy. From 1926 to 1929 he was laboratory chief at Foxboro (Mass.) State Hospital. He was pro-

fessor of psychiatry at Iowa State University from 1929 to 1939 and then was clinical director and research director at Worcester (Mass.) State Hospital from 1939 to 1946. He was professor of psychiatry at the Boston University School of Medicine and psychiatrist in chief at Massachusetts Memorial Hospital from 1946 to 1958, when he assumed his present positions. Dr. Malamud is certified in both psychiatry and neurology by the American Board of Psychiatry and Neurology, and he is the author of about 125 publications.

JOSEPH ROBERT COWEN, M.D. Dr. Cowen was born in Washington, D.C. in 1923. He received his medical degree from the University of Maryland in 1950. He interned at Wayne County General Hospital, Eloise, Mich., and received his residency training in psychiatry at Spring Grove State Hospital, Baltimore. He has served, in various capacities, on the staffs of Spring Grove State Hospital and Sheppard and Enoch Pratt Hospital in Baltimore. He is now in private practice. He is a diplomate of the American Board of Psychiatry and Neurology and the National Board of Medical Examiners.

NEWS AND COMMENT

NARCOTIC RESEARCH UNIT PLANS GO FORWARD

The first full-time narcotics research unit in the State of New York will be opened at Manhattan State Hospital on Ward's Island, New York City, in the summer of 1959, it has been announced by New York State Commissioner of Mental Hygiene Paul H. Hoch, M.D. The unit will provide 55 beds for in-patients, have facilities for treating about 150 out-patients, and will be complete with laboratory facilities. It will be operated in conjunction with a new program of treatment and clinical research to be conducted by the City of New York.

Dr. Hoch said the new unit would pay particular attention to the biological factors involved in the problem of addiction. Much study has already been devoted to psychiatric and social factors of addiction; and the new facility will devote its efforts in particular to the problem of physical dependence, which, Dr. Hoch remarked, is "apparently to a large extent chemical." It is the biological aspect of addiction, the commissioner said, "which offers the most challenging problem and the one that must be solved if drug addiction is to be controlled."

GARDNER ANNOUNCES HUTCHINGS LECTURE TOPIC

"Child Development and the Childhood Behavioral Disabilities" will be the topic of the eleventh Richard H. Hutchings Memorial Lecture, to be delivered by George E. Gardner, M.D., at the College of Medicine, University of the State of New York, Upstate Medical Center, Syracuse, it is announced by Dr. Gardner. The lecture, at 8 p.m., Monday, October 5, 1959, is one of a series sponsored by a group of Dr. Hutchings' colleagues and friends, and is open, without charge, to all members of the medical profession and to all medical students. Dr. Hutchings, former editor of this *QUARTERLY*, former president of the American Psychiatric Association, and former superintendent of both Utica and St. Lawrence (New York) state hospitals, died in October 1947. He was professor emeritus of clinical psychiatry at the Syracuse University College of Medicine, now part of the Upstate Medical Center, where the lecture will be given.

Dr. Gardner is director of the Judge Baker Guidance Center of Boston and editor of the *American Journal of Orthopsychiatry*; besides his M.D., he has a Ph.D. in education from Harvard; he is lecturer and clinical professor of psychiatry at Harvard and lecturer in psychiatry at Boston University.

George L. Warner, M.D., director of Craig Colony, the New York State institution for epileptics, will deliver the customary eulogy on Dr. Hutchings which accompanies the memorial lecture. He served for seven years as a young physician under Dr. Hutchings on the Utica State Hospital medical staff.

HOWARD W. HAGGARD, M.D., DIES AT 68

Howard W. Haggard, M.D., retired director of the Laboratory of Applied Physiology at Yale, founder of the Yale Center of Alcohol Studies, founding editor of *The Quarterly Journal of Studies on Alcohol*, and widely-known writer on medical subjects, died at his home in Fort Lauderdale, Fla., April 23, 1959, at the age of 67. Dr. Haggard, who received his M.D. degree from Yale in 1917, was on the Yale faculty for 37 years, retiring because of ill health in 1956, but retaining the editorship of the *Quarterly Journal*, which he founded in 1940.

Besides scientific writing, Dr. Haggard was the author of a number of popular books on medical subjects, of which *Devils, Drugs and Doctors* was a best-seller for years. Others were: *Noxious Gases; Science of Health and Disease; The Lame, the Halt, and the Blind; Alcohol, Science and Society*; and *Alcohol Explored*. Dr. Haggard was a physiologist, and his early work was in the field of respiratory physiology. His researches are credited with having brought about advances in the development of the gas mask, in mine rescue, in decompression in caisson work and diving, in resuscitation, gas poisoning and electric shock. His work in alcohol studies, however, concerned the psychiatric, psychological and social aspects of the field as much as the physiological. He was responsible for the development of the widely known Summer School of Alcohol Studies at Yale, for persons with widely varying sociological and scientific interests in the subject.

"LILLY KOKOMO PROJECT" REPORT MADE

A progress report has been issued by the University of Chicago on an endeavor known as the Lilly Kokomo Project on "The Role of the Clergyman in Mental Health," a clinical course for clergymen in pastoral care and counseling. With Lilly Endowment, Inc., of Indianapolis paying the expenses of the participants, 23 of the 40 clergymen of Kokomo, Ind., attended an intensive one-week course at the University of Chicago in June 1958. A series of clinical sessions was held in Kokomo over a period of six months, with a Kokomo psychiatrist, who had attended the week's session at the university, present. A second week at the university followed, with another series of clinical sessions, this time with representatives of

law, medicine, social work, labor, industry and education taking part, following the second week at Chicago.

Ten of the 17 Kokomo pastors who did not attend the 1958 course will attend the regular two-week course at the university in June 1959. The university announces that it now plans, instead of inviting ministers from all parts of the country, to invite ministers from one community at a time to its summer courses, giving one week in June and another in September, with clinical work in the home community in between. The university report comments that, although thousands of theological students have now had some training, 325,000 of the 350,000 clergymen in the United States "have had little orientation into the field of psychology." Among the objectives, cited by the university for the course, is "to demonstrate the feasibility of such clinical courses in other medical-theological centers of the nation."

RICHARD M. BRICKNER, M.D., IS DEAD AT 62

Richard M. Brickner, M.D., neurologist and psychiatrist who retired two years ago to engage in research and writing, died in New York City on April 25 at the age of 62. He was assistant clinical professor of neurology at the College of Physicians and Surgeons, Columbia University, before his retirement. He was a past president of the New York Neurological Society and a member of the Harvey Cushing Society. He was a member of the American Psychiatric Association and was certified in both psychiatry and neurology by the American Board of Psychiatry and Neurology. He was a founder and an honorary fellow of the National Multiple Sclerosis Society and had devoted much time and interest to the multiple sclerosis problem. He was probably most widely known outside professional circles as the author of *Is Germany Incurable?*, a psychiatric study of Naziism and its antecedents. His professional writing included a book, *Intellectual Functions of the Frontal Lobes*.

MENTAL HEALTH BOOKLETS IN SPANISH

The National Association for Mental Health announces the translation into Spanish of three mental health booklets of which more than 10,000,000 copies each have been distributed in their English versions. The pamphlets are intended for use in Spanish-speaking communities in the United States and in Latin America. They were translated by the Bureau of Mental Hygiene of the Puerto Rican department of health and have been gone over for authenticity by Mexican and Cuban authorities. The English titles of the translated booklets are: "What Every Child Needs for Good

Mental Health," "Some Things You Should Know About Mental and Emotional Illness" and "Mental Health 1-2-3."

The national association has just issued another booklet, "New Trends in the Care and Treatment of the Mentally Ill," covering the open hospital, the acceptance of mental patients by many general hospitals, and other recent developments. This booklet will be distributed through state and local affiliates of the national association, industrial, health and welfare agencies, trade unions and community organizations.

S. D. VESTERMARCK, M.D., DIES AT 56

Seymour D. Vestermarck, M.D., psychiatrist and retired official of the United States Public Health Service, died in Baltimore on February 22 after a long illness. He was 56 years old. Dr. Vestermarck was known widely through his former position as chief of the training and standards branch of the National Institute of Mental Health. He administered the part of the National Mental Health Act concerned with increasing numbers and quality of professional personnel in the mental health field. The American Psychiatric Association cited him for "his outstanding service to psychiatry," saying that he had had more influence in the field of psychiatric training "than any other one person."

EVANS HEADS NEUROPSYCHIATRIC GROUP

Harrison Evans, M.D., was elected president of the Central Neuropsychiatric Association at its annual meeting in Chicago in March. Other officers are Marvin Adland, M.D., vice president; Ralph Green, M.D., secretary-treasurer, and Martin H. Hoffman, counselor.

VINELAND OFFERS EDUCATIONAL FILM LOAN

The Vineland (N.J.) Training School is offering the loan of a film, "Into the Sunlight," to groups and organizations interested in the problem of mental retardation. It is a 28-minute sound film, produced in co-operation with the National Broadcasting Company, and has been shown on television programs and at group meetings for the past two years. The Training School is offering the loan of the film without charge except for return postage and insurance for \$100.

INSTITUTION FOUNDATIONS ANNOUNCE PLANS

Plans for research and development have been announced by two foundations set up by private psychiatric institutions, the Gralnick Foundation sponsored by High Point Hospital, Port Chester, New York, and the newly-

formed Timberlawn Foundation for Education and Research in Dallas, Texas. The Timberlawn project calls for the financing of a review of 12,000 cases of mental illness treated since 1917 at Timberlawn Sanitarium, the oldest private psychiatric hospital in the southwest. Existing Timberlawn training and research programs are to be intensified.

The Gralnick Foundation, unusual in that it is organized by the professional people who conduct it, has already disbursed two grants for mental health activity and public education, and eight for research, professional education and training. It also has contributed to the support of nonprofit treatment clinics. One Gralnick Foundation grant has been made to the Academy of Psychoanalysis, Chicago, to establish the Frieda Fromm-Reichmann Memorial Award. The award will be made annually for a "significant contribution to the field of psychiatry."

GAP ISSUES REPORT ON "WORKING ABROAD"

A 48-page booklet, reporting on the psychological problems of working abroad, has been issued by the Group for the Advancement of Psychiatry. The report, prepared by a committee under the chairmanship of Bertram Schaffner, M.D., of New York, finds that "separation anxiety," usually acute when a person arrives abroad, is the principal cause of later failure overseas. To avoid failure caused by exacerbation of separation anxiety under conditions of stress, the study recommends that more attention be paid to the mental health of persons sent abroad, even if technical requirements for their work have to be lowered.

"OFFICE MANAGEMENT" TO BE TOPIC OF LECTURES

"Office Management of Emotional Disorders" will be the theme of the 1959-1960 lecture series of the North Shore Hospital, Winnetka, Illinois. The series will be given on the first Wednesday of every month from October through June. John I. Nurnberger, M.D., will deliver the October lecture on "Diagnostic Signs and Symptoms of Emotional Disorders."

MACKINNON HEADS VANDERBILT PSYCHIATRIC CLINIC

Lawrence C. Kolb, M.D., professor of psychiatry at the Columbia University College of Physicians and Surgeons and director of the New York State Psychiatric Institute, announces that Dr. Robert Senescu has been appointed professor and chairman of the department of psychiatry at the Medical College of Virginia. Dr. Senescu has resigned as chief of the Vanderbilt Psychiatric Clinic, and Dr. Roger MacKinnon has assumed this position on a full-time basis.

"LARBEREC" ISSUES BOOKLET

"Larberec," a club sponsored by the Federation of the Handicapped, New York City, announces the issue of a 24-page booklet planned and gotten out by the club membership of 28 young people. The club, the name of which is "cerebral" spelled backward, was formed six years ago "to dispell forever the myth of backward cerebral palsy patients." The booklet describes the efforts of its members, most of whom suffer from cerebral palsy, to overcome their handicaps and "ease the bitterness they felt in many cases."

MRS. KIRKPATRICK HEADS SOCIAL SERVICES

The appointment of Mrs. Mabel D. Kirkpatrick as director of social services in the New York State Department of Mental Hygiene has been announced by Paul H. Hoch, M.D., commissioner of the department. She succeeds Hester B. Crutcher who retired as director last year. Mrs. Kirkpatrick has been in social service in the department for more than 30 years, at Marey and Utica state hospitals, the Aftercare Clinic in New York City, Rome State School, and the Albany office of the department.

STATE UNIVERSITY ANNOUNCES TRAINING COURSES

The graduate educational program of the State University of New York, Downstate Medical Center, Brooklyn, announces a two-year course of research training in psychiatry, leading to the degree of doctor of medical science. The program is open to doctors who have completed three years of residency training in psychiatry; and a fellowship of \$7,500 will be granted for the first post-residency year, and \$8,000 for the second. Candidates may be accepted after two years of residency, in which case they will take their final year of residency at the psychiatric division of Kings County Hospital, Brooklyn, with a stipend of \$7,100 for the final residency year. Applications for the academic year beginning September 1960 should be submitted before January 1, 1960.

MENNINGER AWARD TO PHYLLIS GREENACRE

The Charles Frederick Menninger Award of the American Psychoanalytic Association, given annually for outstanding contributions to theory and practice, has been given for 1959 to Phyllis Greenacre, M.D., New York City psychoanalyst and clinical professor of psychiatry at the Cornell University School of Medicine. Dr. Greenacre is known for psychoanalytic interpretations of Swift, Carroll and others, and has done much work in the field of child and personality development.

SEX SOCIETY TO ISSUE JOURNAL

The Society for the Scientific Study of Sex announces that a new journal, *The Journal of Sexual Research*, will be published, with its first issue early in 1960. The journal is to include original articles, reviews of the literature, book reviews and abstracts covering all the disciplines pertinent to the study of sex.

The society announces that its second annual meeting will be on November 7 in the Barbizon Plaza Hotel, New York City. There will be two symposia, one on "The Psychological Factors in Infertility," the other on "What is Sexually Normal"?

LORAND AWARD IS ESTABLISHED

Graduates and senior candidates of the division of psychoanalytic education, department of psychiatry, State University of New York, Downstate Medical Center, Brooklyn, are establishing a yearly essay award in honor of Sandor Lorand, M.D., founder and director of the division, it is announced by the Psychoanalytic Association of New York. The prize is to be given to the senior candidate or graduate of the division of psychoanalytic education who presents the best paper of the year before the psychoanalytic association.

A dinner in honor of Dr. Lorand, was held on April 4, 1959 to celebrate the anniversary of the education division which is now in its tenth year.

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